U.S. Department
of Transportation
**United States
Coast Guard**

PHYSICAL DISABILITY EVALUATION SYSTEM

COMDTINST M1850.2C

U.S. Department of Transportation
United States Coast Guard

Commandant
United States Coast Guard

2100 Second St. S.W.
Washington, DC 20593-0001
Staff Symbol: G-WPM
Phone: (202) 267-2758

COMDTINST M1850.2C
JUL 19 1996

COMMANDANT INSTRUCTION M1850.2C

Subj: PHYSICAL DISABILITY EVALUATION SYSTEM

1. PURPOSE. This Manual publishes policies, procedures, and standards for administering the Coast Guard Physical Disability Evaluation System for military personnel throughout the Coast Guard.

2. ACTION. Area and district commanders, commanders of maintenance and logistics commands, commanding officers of headquarters units, and Commandant (G-A, G-H, G-L, G-M, G-O, G-S, G-W) and special staff divisions at Headquarters shall ensure compliance with the provisions of this manual.

3. DIRECTIVES AFFECTED. COMDTINST M1850.2B is cancelled.

4. SIGNIFICANT CHANGES.

   a. This revised manual reflects organizational changes and delegations of authority associated with the establishment of the Coast Guard Personnel Command. Other changes simply clarify existing policies and procedures.

   b. Significant policy or procedural changes represented in this revision are summarized as follows:

      (1) An audio recording will serve as the verbatim record of Formal Physical Evaluation Board (FPEB) proceedings in all cases, except where otherwise directed by the permanent president of the FPEB (chapter 5).

4. b. (2) The FPEB will no longer make a recommendation to the evaluee's command as to duty and assignment status of the evaluee pending final determination of the case (chapter 5).

(3) The Physical Review Council (PRC) is no longer required to review cases where the evaluee accepts a board's findings and recommended disposition (chapter 6).

(4) The PRC is given more flexibility in actions it can take when it identifies errors in the record of the Central Physical Evaluation Board (CPEB) or FPEB (chapter 6).

5. FORMS AVAILABILITY.

a. Coast Guard Central Physical Evaluation Board Findings and Recommended Disposition, CG-4809, and Coast Guard Central Physical Evaluation Board Findings and Recommended Disposition, CGHQ-4808, are available in Forms Plus Laser.

b. Coast Guard Physical Evaluation Board, CG-3511; Proceedings and Recommended Findings of Coast Guard Physical Evaluation Board, CG-3511A; Physical Evaluation Board Check List, CG-3512; Record of Proceedings of a Coast Guard Physical Evaluation Board, CG-3510; Statement of Rights of Evaluee, CG-3513, and Physical Evaluation Board Review Record, CGHQ-9959, are all stocked by the Coast Guard Personnel Command, the sole user of these forms.

c. The Application for Service-Disabled Veterans Life Insurance (RH), VA Form 29-4364, is available from the nearest Department of Veterans Affairs regional office.

d. The Injury Report for not Misconduct and In-line of Duty Determination, CG-3822; Disability Orders and Notice of Eligibility for Disability Benefits, CG-4671; and Patient's Statement Regarding the Findings of the Medical Board, CG-4920, are stocked at Supply Center Baltimore.

e. The Medical Board Report Cover Sheet, NAVMED 6100/1, is available from the Navy. The Narrative Summary, SF-502, is available from the General Services Administration.

/s/ W.C. DONNELL
Chief, Human resources

RECORD OF CHANGES			
CHANGE NUMBER	DATE OF CHANGE	DATE ENTERED	BY WHOM ENTERED

PHYSICAL DISABILITY EVALUATION SYSTEM MANUAL

TABLE OF CONTENTS

CHAPTER 1

OVERVIEW OF PHYSICAL DISABILITY EVALUATION SYSTEM (PDES)

CONTENTS

CHAPTER 1. OVERVIEW OF PHYSICAL DISABILITY EVALUATION SYSTEM (PDES)

A. Purpose of the System. The PDES exists to ensure equitable application of the provisions of Title 10, United States Code, Chapter 61, which relates to the separation or retirement of military personnel by reason of physical disability. These laws were enacted primarily for the purpose of maintaining a vital and fit military organization with full consciousness of the necessity for maximum use of the avail-able work force. These laws provide benefits for eligible members whose military service is terminated due to a ser-vice-connected disability, and they prevent the arbitrary separation from the service of those members who incur a disabling injury or disease, yet remain fit for duty.

B. General Responsibilities.

1. Commandant. The Commandant is responsible for prescribing regulations to carry out the provisions of Title 10, United States Code, as they apply to the PDES. Except with respect to the categories and circumstances specified in paragraphs 1.E. and 1.F., the Commandant has authority to make all determinations regarding (1) unfit-ness as a basis for retirement or separation by reason of physical disability, (2) the percentage of disability at the time of retirement or separation, and (3) entitlement to disability severance pay.

2. Chief, Human Resources. Commandant (G-W) has overall responsibility for personnel management within the Coast Guard. Commandant (G-W) has the following specific responsibilities relating to the PDES:

   a. oversee the PDES and approve its policies; and

   b. interpret and implement policies emanating from higher authority.

3. Commander, Coast Guard Personnel Command. The Commander, Coast Guard Personnel Command is responsible for executing all aspects of the PDES as follows:

   a. develop and implement operating procedures for the PDES;

   b. review Central Physical Evaluation Board (CPEB) and Formal Physical Evaluation Board (FPEB) proceedings to ensure efficient, timely processing and uniformly equitable consideration of members under applicable laws, policies, and directives;

1.B.3. c. promulgate the precepts for the CPEB, the FPEB, and the Physical Review Council (PRC) and the Physical Disability Appeal Board (PDAB);

d. manage medical and complete administrative aspects of personnel on the Temporary Disability Retired List (TDRL);

e. finalize physical disability cases for the Commandant, and;

f. implement personnel policy regarding the PDES.

4. Chief Counsel. Commandant (G-L) has responsibility for certifying the legal sufficiency of board actions in the PDES. Commandant (G-L) has specific responsibility as follows:

a. review the actions of the CPEB, FPEB, PRC, and PDAB for legal sufficiency to ensure:

(1) the proceedings are in accepted form and technically correct; and

(2) the findings and recommended disposition are supported by the evidence of record;

b. detail legal counsel to full time support of the PDES to counsel members who are being evaluated by the PDES. This includes legal counsel to brief the evaluee on CPEB findings and recommended disposition and, if applicable, to represent the evaluee before FPEB and PDAB proceedings; and

c. render opinions as requested by the Commander, Coast Guard Personnel Command, on the laws and regulations which govern the PDES.

5. Commanders of Districts and Maintenance and Logistics Commands (MLCs). Commanders of districts and MLCs have specific responsibilities as follows:

a. convene medical boards when required; and

b. review medical boards forwarded to them for any indication of fraudulent enlistment. Any boards in which it appears there may have been fraudulent enlistment will be forwarded immediately to Command-er (CGPC-adm-1) Coast Guard Personnel Command, for determination.

1.B.6. Commanding Officers. Commanding officers have the following responsibilities:

a. become familiar with the purpose of and the policies and procedures governing the PDES and comply with the detailed instructions in paragraph 3.I.;

b. upon receipt of the medical board report, ensure the board includes all items required by chapter 3; Findings of the Medical Board);

d. provide the evaluee with a copy of the board, unless it has been determined by competent medical authority that disclosure of the contents of the medical board might adversely affect the evaluee's physical or mental health;

e. ensure the evaluee is counseled about the contents of the board report subject to the restrictions of paragraph 1.B.6.d.;

f. have the evaluee sign the CG-4920;

g. endorse the medical board report with a full recommendation based on knowledge and observation of the evaluee's motivation and ability to perform military duty;

h. distribute the medical board report in accordance with paragraph 3.K; and

i. establish an interim duty status for the evaluee during PDES processing, following guidelines in paragraph 3.L;

j. forward any case of suspected fraudulent enlistment to Commander (CGPC-adm-1), Coast Guard Personnel Command.

C. System Components. The Physical Disability Evaluation System consists of the following components. These components and levels of review represent a system of counterbalances; each plays an important role in protecting the rights and interests of both the evaluee and the Government.

[NOTE: Full and complete descriptions of these components, their roles, membership, convening authorities and limitations, are provided in the definition section of chapter 2 and in chapters 3 through 9.]

1.C.1. Medical Board (MB). This is the first step in the physical disability evaluation system. Medical boards are convened to conduct a thorough and expeditious evaluation of a member whose fitness for duty is questionable. (chapter 3)

2. Central Physical Evaluation Board (CPEB). The CPEB is a standing administrative board located at the Coast Guard Personnel Command and convened by precept of the Commander, Coast Guard Personnel Command. The CPEB evaluates medical boards as well as periodic evaluations of Members on the TDRL. (chapter 4)

3. Formal Physical Evaluation Board (FPEB). The FPEB is a standing board located at the Coast Guard Personnel Command and convened by precept of the Commander, Coast Guard Personnel Command. The FPEB meets to evaluate a case of an evaluee who has exercised the right to demand a formal hearing subsequent to the evaluation of the case by the CPEB, or upon which the CPEB could not unanimously agree. The formal board is a fact finding body which evaluates the evidence presented, hears witnesses, and records their testimony so as to provide a full and fair hearing. When authorized by Commander, Coast Guard Personnel Command, commanders of maintenance and logistics commands, district commanders, and commanding officers of certain headquarters units may convene a formal board. (chapter 5)

4. Physical Review Council (PRC). The Physical Review Council reviews CPEB's and FPEB's in which evaluees rebut the findings or recommended disposition. (chapter 6)

5. Physical Disability Appeal Board (PDAB). The Physical Disability Appeal Board is established for the purpose of reviewing disability evaluation cases forwarded to it by the PRC. It is the final component in the system. (chapter 7)

D. The PDES Process.

[NOTE: The provisions of this section are presented for the purpose of giving, in one location, a general overview of the entire disability process from the initial medical board through final disposition. This section is not to be relied upon as authority for official action; each step in the process is covered in detail in subsequent chapters.]

1. Initial Medical Board (IMB). A member is introduced into the PDES when a commanding officer (or medical officer or higher authority as described in chapter 3) questions the member's fitness for continued duty due to apparent physical and/or mental impairment(s) and directs that a Medical Board (MB) be convened to conduct a thorough examination of the member's physical and/or mental

1.D.1. (cont'd) impairment(s). The results of this examination, prepared in Initial Medical Board (IMB) format, should be as detailed as possible so as to provide a complete portrait of the member's physical and mental impairments for subsequent review.

2. Commanding Officer Endorsement. The IMB will then be sent to the evaluee's unit for action set forth in paragraphs 1.B.6 and 3.I. The unit commanding officer will prepare an endorsement including an opinion whether or not the evaluee is fit for duty. This endorsement shall reflect the commanding officer's observations of the evaluee's working ability and any impact the injury or disease has on the evaluee's ability to perform the military duties associated with his or her office, grade, rank or rating. The commanding officer shall fully evaluate the more intangible aspects such as motivation and ability to adapt.

3. Evaluee Response to IMB. A copy of the IMB shall also be provided to the evaluee, who will be given an opportunity to comment on the report. To help the evaluee in review- ing the report, the evaluee's commanding officer will arrange assistance by a qualified individual capable of explaining the meaning of the report and the evaluee's rights. If eligible, the evaluee may submit a letter with his or her response to the IMB requesting retention on active duty in accordance with article 17-A or retention in an aviation rating in accordance with article 6-B-4, Personnel Manual, COMDTINST M1000.6 (series).

4. Convening Authority Review. The commanding officer then forwards the entire record, properly endorsed, (including the evaluee's statement, if any) to Commander (CGPC-adm-1),Coast Guard Personnel Command.

5. Commander (CGPC-adm), Coast Guard Personnel Command Referral to CPEB. Commander (CGPC-adm), Coast Guard Personnel Command, will then review the record and if it is sufficient, refer the IMB to the CPEB. Commander (CGPC-adm), Coast Guard Personnel Command, will advise the evaluee's command if a medical board is insufficient and will hold the case in abeyance pending receipt of the required information.

6. CPEB Action. The CPEB sits in closed session and reviews the record of each case referred to it. It does not hear witnesses nor take testimony, but evaluates the fitness and disability of an evaluee solely on the basis of the record before it. CPEB findings and recommended dispo-sition must be unanimous (see paragraph 4.A.6.). The

1.D.6. (cont'd) decision will be provided to the assigned legal counsel, who shall examine the records and review the case and the findings and recommended disposition with the evaluee. Counsel shall explain to the evaluee the full implications of the CPEB's findings and recommended disposition, the evaluee's rights, and alternative CPEB courses of action that should be considered.

7. Evaluee Response to CPEB. The evaluee must then make a decision on the findings and recommended disposition based on the counseling provided (see paragraphs 4.A.14 & 4.A.15 for available options). The time frame for responding is not later than 15 working days from the date indicated on the mailing of the notification of findings from the Coast Guard Personnel Command.

8. FPEB Action and Evaluee Response. Upon receiving a case, the FPEB arranges for the presence of the evaluee and witnesses. This board provides the full and fair hearing which, if demanded by an evaluee, is required by 10 U.S.C. 1214. An audio recording is made of the testimony and proceedings, witnesses are heard under oath or affirmation, and other evidence may be received to establish the evaluee's fitness or unfitness for duty and the degree of disability, if applicable. The evaluee is given a copy of the audio recording, if requested, and the findings and recommended disposition. He or she is allowed not more than 15 working days from the final adjournment of the FPEB hearing to review and, if desired, to submit a rebuttal to the President, FPEB. If no rebuttal is submitted within the 15 day period, the case is forwarded to Commandant (G-LGL) for review.

9. PRC Action and Evaluee Response. If an evaluee has rebutted the findings and recommended disposition of a CPEB or FPEB, the entire record is reviewed by the PRC. The PRC, in reviewing the record, ensures that: the correct Department of Veterans Affairs Schedule for Rating Disabilities (VASRD) diagnostic code(s) has been assigned; there is no pyramiding of impairments; a correct percentage of disability has been assigned to the VASRD descriptive diagnosis(es); and there is a preponderance of evidence of record to support the findings and, if found unfit, the disability rating. If the CPEB or FPEB findings and recommended disposition are approved by the PRC, or if only minor changes are made, the record is forwarded to Commandant (G-L) for a determination of legal sufficiency and for action by the Commander, Coast Guard Personnel Command. If the PRC does not approve the findings and recommended disposition of the CPEB or FPEB, it will take action as provided in paragraph 6.C. Sub- stitute findings and disposition will be sent to the evaluee, who has the opportunity to rebut or appeal the substitution within 15 working days from the date of its

1.D.9. (cont'd) mailing from the Coast Guard Personnel Command. The PRC will consider the evaluee's comments and will either modify the substitute findings and recommended disposition to accommodate the evaluee, or adhere to substitute findings or disposition and so notify the evaluee of the decision and the right to request a hearing before a PDAB. If a rebuttal statement is not received within the 15 working day period, the evaluee will be deemed to have concurred with the substitute finding. (chapter 7)

10. Legal Review. When an evaluee accepts the findings and recommended disposition of a CPEB, FPEB, or PRC, the record is forwarded to Commandant (G-L) for legal review. If legally sufficient, the record is forwarded to the final approving authority. If legally insufficient, the record is returned to the CPEB, FPEB, PRC, or PDAB with recommended corrective action. A case involving a flag officer is forwarded for review to the Director of Health and Safety (G-WK); thence the record is forwarded to Commandant (G-L) for legal review and transmittal to the final approving authority. See paragraphs 1.E. and 1.F. If legally insufficient, the record is returned to the CPEB, FPEB, PRC, or PDAB with recommended corrective action.

11. PDAB. The PDAB is the final board in the disability system. It will review the record of a case presented to it and will hear statements, in person, of the evaluee and counsel if they wish to make such statements. The PDAB will not normally call witnesses or hear other testimony which is already contained in the record. The PDAB's decision is forwarded to Commandant (G-L) for legal sufficiency review. If legally sufficient, the record is forwarded to the final approving authority. If legally insufficient, the record is returned to the PDAB with recommended corrective action. Upon completion of Commandant (G-L)'s review, the record is returned to the PDAB for completion of necessary endorsements, then forwarded to the final approving authority.

12. Final Action. Policy and procedure regarding final action in physical disability evaluation cases is published in Section 17-B, Personnel Manual, COMDTINST M1000.6 (series).

E. Final Approving Authorities.

1. The incumbents of the following positions will act for the Commandant as Final Approving Authority in all cases except those involving flag officers. The Secretary of Transportation will act on all disability cases involving flag officers found not fit for duty in accordance with paragraph 1.F. The Commandant is Final Approving Author-ity in cases where flag officers are found fit for duty.

1.E.1. a. Chief, Administration Division, Coast Guard Personnel Command, providing the following conditions are met:

(1) the evaluee is in pay grade 0-5 or below,

(2) the incumbent was not a member of a board or PRC for the case,

(3) the findings and recommended disposition were decided unanimously,

(4) the case did not involve either a "not in the line of duty" or "misconduct" determination, and

(5) the evaluee is not concurrently being processed for an Administrative Discharge by reason of misconduct or a Punitive Discharge.

b. Commander (CGPC-c), Coast Guard Personnel Command, provided the incumbent has not been a member of a board or PRC for the case.

c. Commandant (G-WP), in all other cases, provided the incumbent has not been a member of a board for the case.

2. The findings and recommended disposition made during the physical disability evaluation process are not binding on a final approving authority. In the event a final approving authority has doubts or questions concerning a particular case to the point where that authority would consider other findings and recommended disposition, the case should be returned to the appropriate board, with appropriate comment. Having followed this procedure, when the final approving authority does not accept the findings and recommended disposition of the Board, he or she will provide an explanation.

F. Flag Officers.

1. An officer in grade 0-7 or higher who is eligible for retirement may not be retired for physical disability unless the officer's unfitness for duty determination and disability retirement is approved by the Secretary of Transportation on the recommendation of the Director of Health and Safety (G-WK).

2. In the case of a flag officer, the next senior officer in the chain of command is the official responsible for preparing the commanding officer's endorsement pursuant to paragraph 3.I.7.

1.F.3. When a flag officer is being processed by the PDES, a flag officer will be assigned as President of the CPEB and as President of the FPEB. Precepts for the CPEB, FPEB, and PDAB evaluating a flag officer will be prepared by Commander, Coast Guard Personnel Command and promulgated by Commandant (G-CCS).

4. In the event substitute findings and recommended disposition by the PRC are rejected by the evaluee, and meet the requirements in paragraph 6.C.2., the case will be referred to a PDAB convened by the Commandant to hear such cases. (Refer to chapter 6 for details)

5. The President of any CPEB, FPEB, or PDAB convened to consider a flag officer on active duty will be senior to the evaluee, if practicable. Membership on these boards may consist of officers not on active duty.

6. In the event of an expedited review case for a flag officer, the provisions of this section are inoperative. The case will be referred to the CPEB convened by the Commander, Coast Guard Personnel Command.

CENTRAL PHYSICAL EVALUATION BOARD FLOWCHART

Exhibit 1-1

FORMAL PHYSICAL EVALUATION BOARD FLOWCHART

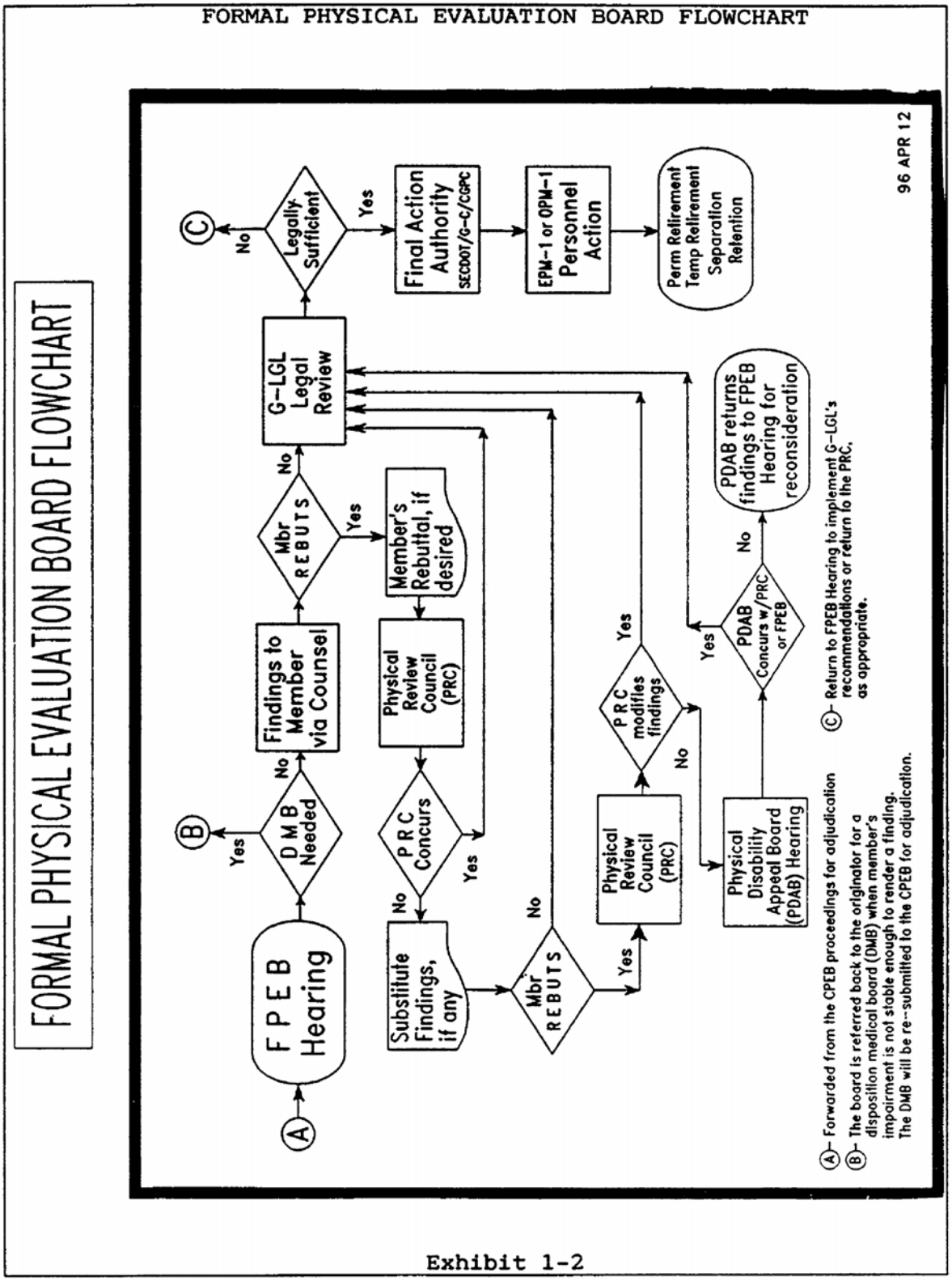


Exhibit 1-2

TABLE OF BENEFITS
PHYSICAL DISABILITY RETIREMENT AND SEVERANCE PAY

Benefit	Category	Less Than 20 Years <- - - - - - Active Service - - - - - ->	20 or More Years
Severance Pay[2]	Regular or reservist ordered to active duty for more than 30 days	Under 30% and incurred in line of duty or proximate result of performing active duty[1]	Severance Pay Not Authorized. See Retirement.
	Reservist ordered to active duty for 30 days or less or on inactive duty training	Under 30% and proximate result of performance of duty. Incurred in line of duty	Severance Pay Not authorized. See Retirement.
Retirement[3]	Regular or reservist ordered to active duty for more than 30 days.	30% or more, and incurred in line of duty or proximate result, [1] of performing active duty.	Any percentage
	Reservist ordered to active duty for 30 days or less, or on inactive duty.	30% or more and proximate result of performance of duty. Incurred in line of duty.	Any percentage

1 10 U.S.C. 1209 and 1332. Member can elect Inactive Status List (ISL) if qualified for retirement

2 There is no payment of severance pay when the evaluee has less than 6 months service at time of separation. See 39 CompGen 291.

3 See chapter 2 for instructions for determination as to temporary or permanent retirement.

Exhibit 1-3

CHAPTER 2

DEFINITIONS, PRESUMPTIONS, AND POLICIES

CONTENTS

CHAPTER 2. DEFINITIONS, PRESUMPTIONS, AND POLICIES

A. Definitions.

1. Accepted Medical Principles. Certain medical principles based upon the observation of a large number of cases and now so universally recognized and consistent with medical facts as to compel unquestionable conclusions and to create a virtual certainty that they are correct. For example, infectious diseases have incubation periods which can define the time of incurrence and certain chronic diseases have well defined clinical courses with remissions and relapses.

2. Active Duty. Full-time duty in the active military service of the United States. It includes duty on the active list, full-time training duty, annual training duty, and attendance, while in the active military service, at a school designated as a service school.

3. Active Duty for a Period of More Than 30 Days. Active duty under a call or order that does not specify a period of 30 days or less.

4. Aggravated by Service. A measurable or demonstrated increase in the level of a member's impairment in excess of that due to the natural progress of a disease or injury which occurs after a member enters active duty in the Coast Guard or during inactive duty training.

5. Armed Conflict. An armed conflict may include a war, expedition, occupation, battle, skirmish, raid, invasion, rebellion, insurrection, guerrilla action or insurgency, etc., in which American military personnel are engaged with a hostile or belligerent nation, faction, or force.

6. Clear and Convincing Evidence. This term means such evidence as would convince an ordinarily prudent-minded person beyond a well-founded doubt. It is a higher degree than preponderance of the evidence, but it does not require proof beyond a reasonable doubt as in criminal cases.

7. Conditions or Defects not Physical Disabilities. Certain conditions and defects may cause a member to be unfit for continued duty and yet not be physical disabilities within the meaning of the law, thereby subjecting the member to administrative separation. These conditions include, but are not limited to, alcoholism; allergy to uniform clothing; character disorders; enuresis; heat intolerance with disturbances of thermal regulation; inability to be fitted in uniform clothing; motion/travel sickness; obesity; primary mental deficiency; pseudofolliculitisbarbae of the face and/or neck; somnambulism;

2.A.7. (cont'd) stuttering or stammering; systemic or marked allergic reactions following stings by red ants, bees, wasps or other stinging insects; unsanitary habits including repeated venereal disease infections. (A full listing of personality and intelligence disorders is contained in chapter 5, Medical Manual, COMDTINST M6000.1(series).)

8. Counsel. Attorneys assigned by the Commandant (G-L), a civilian employed by the evaluee at no expense to the government, or a disability counselor provided by a veterans' service organization.

9. Deleterious to Health Type Case. Situations, medical boards, or disability cases in which disclosure of information on a member's physical condition would be harmful or detrimental to that individual's physical or mental health.

10. Disease. A definite morbid condition which is not caused by trauma and has a characteristic group of symptoms. A disease may affect the whole body or any of its parts, and its cause, pathology, and prognosis may be known or unknown.

11. Disposition Medical Board (DMB). The report of a medical board ordered normally by the President of the CPEB to reevaluate those conditions addressed by an Initial Medical Board (IMB). DMB's are usually ordered when the President of the CPEB or the convened CPEB feels that the evaluee's disease or injury was not sufficiently manifested at the time of the IMB to determine the cause or degree of the evaluee's impairments. Additionally, DMB's will also evaluate any new conditions which were not present or considered at the time of the IMB. The time frame of the DMB is specified in the convening order.

12. Evaluee. The member whose case is being considered. (see Legal Guardian)

13. Existed Prior to Entry (EPTE). An impairment which existed prior to an evaluee's entry onto active or inactive duty.

14. Expedited Review Cases. Those cases stemming from casualties or terminal illnesses where death is likely to occur within a short time. Though these cases will be evaluated within the PDES, just as any other PDES case, they shall be processed by the fastest means of communication available.

2.A.15. Fit For Duty (FFD). The status of a member who is physically and mentally able to perform the duties of office, grade, rank or rating. This includes specialized duty such as duty involving flying or diving only if the performance of the specialized duty is a requirement of the member's enlisted rating.

16. Fit for Limited Duty (FFLD). The interim status of a member who is temporarily unable to perform all of the duties of the member's office, grade, rank or rate. A member placed in this temporary status will have duty limitations specified, such as: no prolonged standing, lifting, climbing; or unfit for sea or flying duty.

17. Grade, Rank and Rating. The terms "grade", "rank" and "rating" are defined by statute (10 U.S.C. 101 (b)) as follows:

a. Grade. A step or degree, in a graduated scale of office or military rank, that is established and designated as a grade by law or regulation.

b. Rank. The order of precedence among members of the Armed Forces.

c. Rating. The name (such as "boatswain's mate") pre-scribed for members of an armed force in an occupational field. The term "rate" means the name (such as "chief boatswain's mate") prescribed for members in the same rating or other category who are in the same grade (such as chief petty officer or seaman apprentice).

18. Impairment of Function. Any lessening or weakening of the capacity of the body or any of its parts, to perform that which is considered by accepted medical principles to be the normal functional activity in the bodily economy.

19. Impairment, Latent. An impairment which is not currently manifested by current signs and/or symptoms, but which is of such a nature that there is reasonable probability, according to accepted medical principles, that signs and/or symptoms that demonstrate impairment of function will definitely appear within a period of time.

20. Impairment, Manifest. An impairment of function that currently exists which can be diagnosed by signs and/or symptoms.

21. Impairment, Physical. Any anatomical, functional or physiological abnormality of the body. Synonymous with "physical defect." Included is an alteration of mental capacity due to disease or injury.

2.A.22. Inactive Duty Training (IDT). Duty prescribed by competent authority for members of Reserve components under provision of 37 U.S.C. 206, 37 U.S.C. 1002, or 10 U.S.C. 12315.

23. Incurrence of Disability. A disability is incurred (as in "incurred while entitled to receive basic pay") when the disease or injury is contracted or suffered as distinguished from a later date when the member's physical impairment is diagnosed or the physical defect renders the member unfit for continued duty. After the member is found unfit for continued duty, incurrence of disability is synonymous with the incurrence of an impairment. A physical disability that is due to the natural progress of disease or injury is incurred when the disease or injury causing the disability is contracted.

24. Initial Medical Board (IMB). The written report of a medical board convened by other than the order of the President of the CPEB to evaluate a member's fitness for duty and to make recommendations consistent with the findings. (see chapter 3)

25. Injury. A term describing damage done to the body by kinetic (trauma), thermal (burn or frostbite), or chemical (poisoning) means.

26. Legal Guardian. An individual designated as legally empowered to act on behalf of a member whom a court, having jurisdiction in the matter, or the Commandant has declared as incompetent to act on his or her own behalf. In this manual, whenever the term "evaluee" is used it shall be interpreted to include the legal guardian, when one has been appointed. The legal guardian may exercise, on behalf of the evaluee, all rights afforded by this manual.

27. Legal Sufficiency. In general terms, a review for legal sufficiency is primarily intended to ensure that a record is free of any error of law, such as a breach of Federal law or regulation.

28. Maximum Hospital Benefits. That point in time during hospitalization when it is determined that additional hospitalization will not contribute to any further substantial recovery. A member who can be expected to continue to improve over a long period of time without specific therapy or medical supervision or with only a moderate amount of treatment on an outpatient basis, may be considered as having attained maximum hospital benefits. It is not necessary to attain maximum hospital benefits, when those benefits will not lead to a FFD status, in order to begin the physical disability evaluation process.

2.A.29. Medical Board. A medical board is a clinical body normally comprised of one or more medical officers who describe an individual's disease or injury, the physical impairment, and the impairment of function, including any latent impairment. It includes a written professional opinion on whether the member's physical and mental qualifications satisfy the medical standards for retention set forth in the Medical Manual, COMDTINST M6000.1 (series).

30. Member. Unless otherwise specified, a commissioned officer, warrant officer, or enlisted person of the Coast Guard or Coast Guard Reserve, including temporary retired and retired persons. Cadets are not members.

31. National Emergency. A period of time during which the President is granted statutory authority to suspend the provisions of specific Federal laws.

32. Natural Progress of the Disease. The exacerbations and remissions and increase in severity or disabling effect of a disease or injury that normally occurs over a period of time by reason of the inherent character of the disease.

33. Office. A duty assigned to or assumed by someone. For the purposes of the PDES, office is defined as the member's assigned duties.

34. On-Scene Coordinator. An officer, or when an officer is not reasonably available, an enlisted member, E-7 or above, appointed by a command requesting expedited review of a member's case where death may be imminent. The person so assigned will gather all pertinent personnel and medical evidence.

35. Periodic Physical Examination. For a member on active duty, refers to any physical examination required by the Medical Manual, COMDTINST M6000.1 (series), or the Personnel Manual, COMDTINST M1000.6 (series). For a member on the Temporary Disability Retired List (TDRL), refers to examinations required by paragraph 8.C. of this manual.

36. Permanent Disability Retirement. A PDES final action that retires an evaluee who is unfit for continued duty by reason of a physical disability which is permanent and stable.

37. Permanent Disability Separation with Severance Pay. A PDES final action that separates an evaluee who is unfit for continued duty by reason of a physical disability.

2.A.38. Physical Disability. Any manifest or latent physical impairment or impairments due to disease, injury, or aggravation by service of an existing condition, regardless of the degree, that separately makes or in combination make a member unfit for continued duty. The term "physical disability" includes mental disease, but not such inherent defects as behavior disorders, personality disorders, and primary mental deficiency.

39. Physical Disability Evaluation System. The structure within the Coast Guard composed of administrative boards and reviewing and approving authorities for evaluating a member's physical ability to perform the duties associated with the member's office, rank, grade, or rating, and the equitable application of the laws and regulations relating to separation or retirement of members because of physical disability.

40. Predisposition. A special tendency toward developing a particular disease or condition due to heredity or environment.

41. Preponderance of the Evidence. A degree of proof based on superior quality of evidence rather than quantity. Preponderance does not necessarily mean a greater number of witnesses or greater mass of evidence; rather, preponderance means a superiority of evidence on one side or the other of a disputed fact. A fact will be proved by a preponderance of the evidence when the evidence tending to prove the fact qualitatively supports the establishment of the fact, no matter how slightly, more than the evidence tending to disprove the fact.

42. Presumption. A presumption is a proposition of fact. Matters which are "presumed" need no proof to support them. Usually a presumption is rebutted by clear and convincing evidence. (see paragraph 2.B.)

43. Proximate Result of Military Service. A disease or injury or aggravation thereof, resulting in physical disability which, after consideration of all facts and circumstances of a particular case, may reasonably be regarded as an incident of military service or may reasonably be assumed to be the effect of military service. The disease or injury did not result from an intervening cause unusual to active or inactive duty. (see paragraph 2.C.9.)

44. Reasonable Doubt. A reasonable doubt exists when the evidence is insufficient to either prove or disprove a fact.

45. Separation. A termination of military status.

46. Separation for Disability. See paragraph 2.A.37.

2.A.47. Service-connected. "Service-connected" means, with respect to disability or death, that such disability was incurred or aggravated, or that the death resulted from a disability incurred or aggravated, in line of duty in the military, naval, or air service.

48. Temporary Disability Retirement. A PDES final action which, if the disability were of a stable nature, would qualify an evaluee for a Permanent Disability Retirement. An evaluee who is being temporarily retired will be placed on the Temporary Disability Retired List (TDRL)

49. Unauthorized Absence. Any absence from military duty without authority (such as contemplated under Article 86 of the Uniform Code of Military Justice).

50. Unfit for Continued Duty (Unfit). The status of a member who is physically and/or mentally unable to perform the duties of office, grade, rank, or rating because of physical disability. The status of unfitness applies to a member unable to perform specialized duty, such as duty involving flying or diving, only if the performance of the specialized duty is a requirement of his or her enlisted rating.

51. VASRD. The Department of Veterans Affairs Schedule for Rating Disabilities (38 CFR, part 4). A manual used by PDES boards to assign codes and percentage of disability for an evaluee found unfit for duty.

52 While Entitled to Receive Basic Pay. A member entitled to pay under 37 U.S.C. 204.

B. Presumptions. The following presumptions are applicable to all cases before all physical evaluation boards:

1. An evaluee is presumed to have been fit for duty at the time he or she entered the Coast Guard. The presumption stands unless rebutted by clear and convincing evidence. See paragraph 2.C.5.

2. An evaluee is presumed fit to perform the duties of his or her office, grade, rank or rating. The presumption stands unless rebutted by a preponderance of evidence.

3. Any increase in the degree of a pre-service impairment which occurs during active service is presumed to be due to aggravation unless it is shown to be due to the natural progression of the disease or injury which existed prior to entry on active duty. The presumption stands unless rebutted by clear and convincing evidence.

2.B.4. Injury or disease is presumed to be incurred in the line of duty. The presumption stands unless rebutted by clear and convincing evidence.

5. Injury or disease is presumed not to be due to intentional misconduct or willful neglect. The presumption stands unless rebutted by clear and convincing evidence.

6. An evaluee is presumed to be mentally competent. The presumption stands unless rebutted by clear and convincing evidence.

C. Policies.

1. General Administration. The following policies relate to general administration and guidelines for the PDES: a. The Coast Guard can neither enforce adherence to a physical standard so high that each member with a minor impairment is considered unfit for duty, nor establish a physical standard so low that a member with a physical impairment(s) is required to be specially retained in a billet to the detriment of normal operational efficiency and the normal planned rotation of personnel.

b. Laws pertaining to a disability retirement or separation shall be administered equitably and in good conscience. Although these laws shall be administered in a manner which protects the Government from assuming unwarranted responsibility for payment of disability and retirement benefits, reasonable doubt as to the entitlement of an evaluee shall be resolved in the evaluee's favor. The reasonable doubt doctrine should not be applied if the issue can be resolved by additional evidence. c. The decisions of disability evaluation boards should reflect a consistent application of the standards.

2. Fit For Duty/Unfit for Continued Duty. The following policies relate to fitness for duty:

a. The sole standard in making determinations of physical disability as a basis for retirement or separation shall be unfitness to perform the duties of office, grade, rank or rating because of disease or injury incurred or aggravated through military service. Each case is to be considered by relating the

2.C.2. a. (cont'd) nature and degree of physical disability of the evaluee concerned to the requirements and duties that a member may reasonably be expected to perform in his or her office, grade, rank or rating. In addition, before separation or permanent retirement may be ordered:

(1) There must be findings that the disability:

(a) is of a permanent nature and stable, and

(b) was not the result of intentional misconduct or willful neglect and was not incurred during a period of unauthorized absence.

(2) To warrant retirement, the length of service and degree of disability requirements prescribed in clause (3) of 10 U.S.C. 1201 must be satisfied.

(3) To warrant separation, the degree of disability requirements prescribed in clause (4) of 10 U.S.C. 1203 must be satisfied and the evaluee must have less than 20 years of qualifying service, under the criteria of 10 U.S.C. 1208.

b. The law that provides for disability retirement or separation (10 U.S.C., chapter 61) is designed to compensate a member whose military service is terminated due to a physical disability that has rendered him or her unfit for continued duty. That law and this disability evaluation system are not to be misused to bestow compensation benefits on those who are voluntarily or mandatorily retiring or separating and have theretofore drawn pay and allowances, received promotions, and continued on unlimited active duty status while tolerating physical impairments that have not actually precluded Coast Guard service. The following policies apply:

(1) Continued performance of duty until a member is scheduled for separation or retirement for reasons other than physical disability creates a presumption of fitness for duty. This presumption may be overcome if it is established by a preponderance of the evidence that:

(a) the member, because of disability, was physically unable to perform adequately in his or her assigned duties; or

(b) acute, grave illness or injury, or other deterioration of the member's physical condition occurred immediately prior to or coincident with processing for separation or

2.C.2. b. (1) (b) (cont'd) retirement for reasons other than physical disability which rendered him or her unfit for further duty.

(2) A member being processed for separation or retirement for reasons other than physical disability shall not be referred for disability evaluation unless the conditions in paragraphs 2.C.2.b.(1)(a) or (b) are met.

c. If a member being processed for separation or retirement for reasons other than physical disability adequately performed the duties of his or her office, grade, rank or rating, the member is presumed fit for duty even though medical evidence indicates he or she has impairments.

d. Inadequate performance of duty, by itself, does not constitute physical unfitness. The evidence must establish a cause and effect relationship between the inadequate performance and the evaluee's physical impairments.

e. An evaluee whose manifest or latent impairment may be expected to interfere with the performance of duty in the near future may be found "unfit for continued duty" even though the member is currently physically capable of performing all assigned duties. Conversely, an evaluee convalescing from a disease or injury which reasonably may be expected to improve so that he or she will be able to perform the duties of his or her office, grade, rank, or rating in the near future may be found "Fit for Duty." In this instance, the evaluee will continue in an interim duty status until convalescence is complete, at which time he or she will be returned to a full duty status.

f. The following standards and criteria will not be used as the sole basis for making determinations that an evaluee is unfit for continued military service by reason of physical disability.

(1) Inability to perform all duties of his or her office, grade, rank or rating in every geographic location and under every conceivable circumstance. Where feasible, and if requested by the evaluee, consideration should be given to providing the member an opportunity for a change in rating to one in which the disability is no longer a disqualifying factor.

2.C.2.f. (2) Inability to satisfy the standards for initial entry into military service, except as specified in paragraph 2.C.2.g.

(3) Lack of a special skill in demand by the service.

(4) Inability to qualify for specialized duties requiring a high degree of physical fitness, such as flying, unless it is a specific requirement of the enlisted rating.

(5) The presence of one or more physical defects that are sufficient to require referral for evaluation or that may be unfitting for a member in a differ-ent office, grade, rank or rating.

(6) Pending voluntary or involuntary separation, retirement, or release to inactive status. (see paragraph 2.C.2.b.(1))

g. A member who entered military service with a waiver for a medical condition or physical defect that usually is cause for referral to a physical evaluation board shall normally not be considered unfit because of that physical disability, provided the condition has remained essentially unchanged and has not interfered with the performance of duty. If, however, based on accepted medical principles, the condition presents a risk were the member to remain in military service, separation may be appropriate.

h. An evaluee found unfit to perform assigned duties because of a physical disability normally will be retired or separated. Under special circumstances, disability separation or retirement may be delayed in the best interest of the Government by the Commandant.

i. The existence of a physical defect or condition that is ratable under the standard schedule for rating disabilities in use by the Department of Veterans Affairs (DVA) does not of itself provide justification for, or entitlement to, separation or retirement from military service because of physical disability. Although a member may have physical impairments ratable in accordance with the VASRD, such impairments do not necessarily render him or her unfit for military duty. A member may have physical impairments that are not unfitting at the time of separation but which could affect potential civilian employment. The effect on some civilian pursuits may be significant. Such a member should apply to the Department of Veterans Affairs for disability compensation after release from active duty.

2.C.3. Required Findings by the CPEB, FPEB, and PRC.

a. Evaluee on Active Duty for More than 30 Days (Other than a Ready Reservist on active duty under an invol-untary recall due to delinquency in drill). In these cases the board shall make one of the following findings:

(1) Fit for Duty. If the board finds the active duty evaluee "Fit for Duty," it shall make no other findings.

(2) Unfit for Continued Duty by Reason of Condition or Defect Not a Physical Disability. If the board finds the evaluee unfit for continued duty solely due to a condition or defect not a physical disability within the meaning of the law, it will recommend a finding of "Unfit for Continued Duty." The condition or defect shall be specified, and the following statement added: "Not a disability within the meaning of the law."

(3) Unfit for Continued Duty by Reason of a Physical Disability. If the board finds the evaluee unfit for continued duty by reason of physical disability, the board shall make the finding "Unfit for Continued Duty." The board shall then make the following findings:

(a) propose ratings for those disabilities which are themselves physically unfitting or which relate to or contribute to the condition(s) that cause the evaluee to be unfit for continued duty. The board shall not rate an impairment that does not contribute to the condition of unfitness or cause the evaluee to be unfit for duty along with another condition that is determined to be disqualifying in arriving at the rated degree of incapacity incident to retirement from military service for disability. In making this professional judgment, board members will only rate those disabilities which make an evaluee unfit for military service or which contribute to his or her inability to perform military duty. This policy applies to those evaluees whose initial entry into the PDES occurs subsequent to 9 July 1987. In accordance with the current VASRD, the percentage of disability existing at the time of evaluation, the code number and diagnostic nomenclature for each disability, and the combined percentage of disability will be provided.

2.C.3. a. (3) (a) 1. When rating a condition which does not appear in the VASRD, the board shall rate by analogy (see paragraph 9.A.). The board shall state its diagnosis, followed by the following statement: "Rated by analogy to _____".

2. In cases involving aggravation, the board shall compute the final combined total rating in accordance with paragraph 2.C.6.

(b) whether or not each disability was the result of intentional misconduct, willful neglect, or incurred during unauthorized absence. (see paragraphs 2.C.7. and 2.C.8.)

(c) whether or not each disability was incurred while entitled to receive basic pay. (see paragraph 2.A.52)

(d) that the evaluee either:

1. has at least 8 years of service; or

2. has less than 8 years of service; and

a. whether or not each disability is the proximate result of performance of active duty; (see paragraph 2.C.9.) or

b. whether or not each disability was incurred in line of duty in time of war or national emergency; or

c. whether or not such disability was incurred in the line of duty after 14 September 1978.

(e) whether each disability "is permanent" or on the basis of accepted medical principles "may be permanent."

(f) whether the disability resulted from an injury or disease which was caused by an armed conflict or an instrumentality of war.

[NOTE: Dual compensation laws do not apply in these circumstances.]

2.C.3.a.(3) (g) whether the disability occurred during either combat, extra hazardous service, under conditions simulating war or by an instrumentality of war. (see Public Law 94-455, Section 505 Tax Reform Act of 1976)

(h) whether or not the evaluee is mentally competent.

(i) In the case of an evaluee who has greater than 18 years active duty, but less than 20 years, who has not requested retention as provided in paragraph 3.H.4., the board will make a finding as to whether or not the evaluee meets the medical requirements for retention as established by Chapter 17 and article 6-B-4.f, Personnel Manual, COMDTINST M1000.6 (series).

b. Evaluee on Active Duty for 30 Days or less, Ready Reservists on Active Duty for Training Under an Involuntary Recall Due to Delinquency in Drill, or on Inactive Training Duty. When considering the case of evaluees in this category, the board shall make findings as indicated in paragraph 2.C.3.a. except that, in lieu of a finding of entitlement to basic pay, the board must find whether or not each disability is the proximate result of performing active duty or inactive duty training. (see paragraphs 2.A.43 and 2.C.9).

c. Evaluee on the TDRL. When the case of an evaluee on the TDRL appears before the board, the board shall make independent findings and recommended disposition, based on the evaluee's current status and level of disability. The following policies apply to members on the TDRL:

(1) An evaluee will be continued on the TDRL when an intermediate (not final) periodic examination indicates that his or her condition has not stabilized and that he or she remains unfit for continued duty.

(2) In all other TDRL cases, the provisions of paragraph 2.C.3.a. shall apply, except that the findings required by paragraph 2.C.3.a.(3)(b),(c), and (d) shall not be made for any disability rated at the time of temporary retirement. In

2.C.3.c. (2) (cont'd) such cases, the initial findings approved by the Commandant are binding on all subsequent boards. These findings are, however, required for any impairment not previously rated. Impairments not previously rated shall be considered as incurred while entitled to receive basic pay only when the evidence shows that the condition existed prior to temporary retirement.

(3) An impairment incurred after temporary retirement shall be found "Not incurred while entitled to receive basic pay."

(4) Any impairment which still exists on a periodic physical evaluation held immediately prior to the end of the 5 year period during which the evaluee's name may be carried on the TDRL, shall be rated as permanent.

d. Amplifying Statements. When the basis for its findings and recommended disposition is not readily apparent from the documents of record, as in the case of a disability percentage award varying from the normal, or when the true physical condition of the evaluee is not adequately reflected by the VASRD, the board will prepare an amplifying statement, setting forth the basis for its findings and recommended disposition. Matters of opinion are permissible, but must be clearly indicated as such. The amplifying statement shall be entered in Item 11 of Form CGHQ-4808, or in Item 12 of Form CG-3511A, or on a separate sheet attached thereto.

4. Inception of Impairment. Determinations concerning the time of inception of injury or disease may be based on:

a. material evidence relating to the incurrence, symptoms, and history;

b. accepted medical principles;

c. official and other records made prior to and during service; and/or

d. other pertinent lay and medical evidence.

5. Existed Prior to Entry (EPTE). An impairment rated as EPTE is one which existed prior to a member's entry onto active duty (entitled to receive basic pay) or inactive duty.

2.C.5. a. Clear and convincing evidence is required to establish the existence of an injury or disease before a member's entrance into the Coast Guard. If preexistence is established, but the level of impairment at entry cannot be established, EPTE shall be rated at zero (0) percent. Those physical impairments recorded by an examining physician at the time of entry into the Coast Guard are considered not to have been incurred while entitled to receive basic pay unless the record establishes their inception in the line of duty during prior military service.

b. When accepted medical principles establish the existence of an impairment prior to entrance into service, no other corroborating evidence is necessary. For example:

(1) When residual conditions establish that an injury or disease did not occur during service (e.g., scars; fibrosis of the lungs; atrophy following disease of the central or peripheral nervous system; healed fractures; absent, displaced, or resected parts of organs; supernumerary parts; congenital malformations); or, when manifestations of lesions, or symptoms of chronic disease develop so close to the date of entry into the Coast Guard that it is impossible for the disease to have originated after entry into the Coast Guard. (Infectious conditions shall be considered with regard to the circumstances of infection and the incubation period.); or

(2) When manifestations of a disease develop within less than the minimum incubation period after entry on active or inactive duty; or

(3) When psychiatric conditions are shown to have existed prior to service with manifestations during service.

(a) It is essential that the medical history be reliable and that the evaluee's recall and narration of facts to the attending physician be credible.

(b) When the evaluee's ability to recall and narrate is in doubt, there must be clear and convincing corroborative evidence.

6. Aggravation by Service. The following policies apply to aggravation by service of an injury or disease.

2.C.6. a. Aggravation during Coast Guard service may not be found when the medical evidence confirms the increase in disability to be due solely to the natural progression of a disease or injury which is confirmed to have existed prior to entry.

b. Aggravation may not be found where the impairment underwent no increase in severity during service based on the evidence of record.

c. The usual effects of service-provided medical and surgical treatment to ameliorate disease or other conditions incurred before entry into service (including postoperative scars, absent or poorly functioning parts or organs) do not constitute aggravation.

d. Aggravation by service of a preexisting impairment is determined by finding the combined total percentage of disability existing at the time of evaluation and subtracting there from the combined total percentage of disability:

(1) Existing at the time of entry into active service; or

(2) Incurred during a period of unauthorized absence; or

(3) Otherwise not incurred in line of duty, provided the percentage of disability subtracted can be ascertained in terms of the VASRD. No deduction will be made from a total (100 percent) rating; however, the percentage of disability existing upon entry into the service will be set forth in the record. If the condition(s) which existed upon entry cannot be ascertained in terms of the VASRD, insert zero (0) percent.

[Note: If the current level of disability and the EPTE level are the same, the level of aggravation is to be listed as "NONE", not as zero.]

7. Line of Duty/Misconduct. The CPEB, FPEB, and PRC must make line of duty/misconduct findings and recommended disposition on each case, based on the information of record. The Board members should refer to chapter 5, Coast Guard Administrative Investigations Manual (AIM), COMDTINST M5830.1 (series) for specific guidance. In making their determinations, physical evaluation boards should review any board of investigation, or administrative report which is available, even if final reviewing authority action on the line of duty investigation has not been taken. Physical evaluation boards are bound

2.C.7. (cont'd) by final line of duty determinations which are available at the time the Physical Evaluation Board considers the evaluee's case and which, if adverse to the evaluee, were made after the right to a hearing and representation by counsel were provided. (see paragraph 5.M, Coast Guard Administrative Investigations Manual (AIM), COMDTINST M5830.1(series)) However, the CPEB, FPEB, or PRC may include an explanatory statement and recommendations for consideration by the final approving authority in cases where board members feel, based on the facts presented, the final line of duty determination was inappropriate.

8. Refusal to Submit to Surgical and Medical Treatment.

a. Paragraph 8-2-1, Coast Guard Regulations, COMDTINST M5000.3 (series) states that:

(1) Persons in the Coast Guard shall not refuse to submit to necessary and proper medical or dental treatment to render themselves fit for duty, nor refuse to submit to a necessary and proper operation not endangering life.

(2) Persons in the Coast Guard shall permit such action to be taken as to immunize them against disease as is prescribed by competent authority.

b. It is the policy of the Commandant that forced medical treatment is not permissible at any time. A member, who refuses to submit to those measures considered by competent medical or dental officers to be necessary to restore him or her to a fit for duty status, may be processed for administrative separation from the Coast Guard in accordance with applicable regulations. The member may be subjected to disciplinary action for refusal of necessary treatment or surgery if the refusal is determined to be unreasonable. Surgery shall not be performed on a person over his or her protest if the individual is mentally competent.

c. Refusal of recommended emergency or lifesaving treatment or emergency diagnostic procedures required to prevent increased disability or threat to life is ordinarily determined to be unreasonable. The adequacy of facilities or the existence of more adequate facilities available within a reasonable distance shall be taken into consideration. A medical board shall be convened, comprised of two medical officers or two appropriate specialists, if the medical situation warrants, to establish that the treatment was or

2.C.8. c. (cont'd) is of an emergent nature, and required to counter a threat to life or to decrease subsequent disability.

d. If a member of the Coast Guard refuses elective medical, surgical, dental, or diagnostic procedures, a medical board must be convened to determine whether there is reasonable basis for refusal. This board, comprised of two medical officers or two appropriate specialists (when the determination requires specialized training), shall establish facts and make recommendations concerning the case.

e. The following questions must be answered by the medical board convened in paragraphs (c) and (d) above in making a determination as to reasonable or unreasonable refusal:

(1) What is the probability of the member's ultimate fitness for duty within a reasonable length of time if the procedure is undertaken?

[Note: If the conditions are such that a future status of fitness for duty is impossible, despite successful outcome of the procedure under consideration, it shall be held that the member is reasonable in refusing the treatment. In this case, the below listed questions need not be considered.]

(2) What is the probability of success of the procedure in view of current accepted medical principles?

[Note: While it is recognized that no one procedure has an absolute guarantee of success, certain procedures have a higher degree of expectation of success than others. The consideration at this point is the relationship of the individual case at hand to some accepted, and if known, quantifiable standard of success.]

(3) What is the possible medical hazard to the health and what is the possibility that omission of such procedure would constitute a potential and greater hazard to the member at some future time?

(4) Does age, existing physical or mental condition, or history of prior unsuccessful procedure sufficiently justify refusal of the procedure to overcome the indication for it?

2.C.8. e. (5) Based on the answers to the above questions, is refusal of the procedure in the judgment of the board reasonable or unreasonable?

f. If the convened medical board determines the member's refusal to be unreasonable, the case will be processed through the PDES, but the disability, if found, will be determined to have resulted from misconduct and not in the line of duty. (see chapter 5, Coast Guard Administrative Investigations Manual (AIM), COMDTINST M5830.1 (series))

g. Notification of patient of medical board findings:

(1) If a board decides that diagnostic, medical, dental, or surgical procedures are indicated, these findings must be made known to the evaluee. The board's report shall show that the evaluee was afforded an opportunity to submit a written statement explaining the grounds for refusal. Any statement submitted shall be forwarded with the board's report.

(2) The evaluee shall be advised: (a) that the refusal to accept medical treatment and any statement submitted by the evaluee shall be forwarded with the medical board report; (b) that refusal may lead to separation from the Service without disability benefits; and (c) that an unreasonable refusal may lead to disciplinary action after review of the medical board by the court martial convening authority.

9. Proximate Result of Performing Active Duty. A disability is the proximate result of performing active duty, active duty for training or inactive duty for training when the disability occurs while the member is performing acts consistent with such status, and the disease or injury does not result from an intervening cause unusual to a member performing active or inactive duty, for example, injury while in the employ of a private employer.

10. Is Permanent/May be Permanent. These rules will be applied to the question of permanency of disability:

a. A disability will be categorized "permanent" when it can be reasonably determined that the disability will not improve to the extent that the evaluee will ever return to duty, and:

(1) Accepted medical principles indicate the defect has stabilized to the degree necessary to assess the permanent degree of severity or percentage rating; or

2.C.10.a. (2) The compensable percentage rating can reasonably be expected to remain unchanged for the statutory five year period that the evaluee can be compensated while on the TDRL; or

(3) The compensable percentage rating is 80 percent or more with reasonable expectation that it will not fall below 80 percent during the 5 year period.

b. Those disabilities that, due to the natural progress of the disease or defect, will increase in severity over the next 5 year period, but not to an additional compensable degree (e.g., degenerative arthritis) will be categorized as permanent. A member eligible for normal longevity retirement who by reason of his or her disability will never be expected to return to duty will be considered for permanent disability retirement under the above criteria, provided any impairment can be appropriately rated.

c. A disability will be characterized "may be permanent" if, based upon accepted medical principles, the defect has not stabilized to the degree necessary to assess the permanent degree of severity (percentage rating). This disposition is used only when permanent retirement is inappropriate under the criteria of paragraph 2.C.10.a.

d. Central or Formal Physical Evaluation Boards evaluating TDRL cases for final disposition at the expiration of the five year period during which an evaluee's name may be carried on the TDRL, shall rate any disability which still exists as "permanent," and recommend a disability rating based on the degree of the evaluee's impairment at the time of the evaluation. (see 10 U.S.C. 1210(b))

11. Cases Involving Disability Evaluation and Disciplinary Action Concurrently.

a. Disability statutes do not preclude disciplinary or administrative separation under applicable portions of the Personnel Manual, COMDTINST M1000.6 (series). If a member is being processed for a disability retirement or separation, and proceedings to administratively separate the member for misconduct, disciplinary proceedings which could result in a punitive discharge of the member, or an unsuspended punitive discharge of the member is pending, final action on the disability evaluation proceedings will be suspended, and the non-disability action monitored

2.C.11. a. (cont'd) by the Commander, Coast Guard Personnel Command. (see Article 12-B-1.e., Personnel Manual, COMDTINST M1000.6 (series))

b. If the court martial or administrative process does not result in the execution of a punitive or an administrative discharge, the disability evaluation process will resume. If a punitive or administrative discharge is executed, the disability evaluation case will be closed and the proceedings filed in the member's official medical record.

CHAPTER 3

MEDICAL BOARDS

CONTENTS

CHAPTER 3. MEDICAL BOARDS

A. Purpose. The purpose of a medical board is to evaluate and report upon the present state of health of any member who may be referred to the medical board by an authorized convening authority and provide a recommendation as to whether the member is medically fit for the duties of his or her office, grade, rank, or rating.

B. Convening of Medical Boards.

1. A medical board may be convened by the following:

   a. Commandant;

   b. Area Commanders;

   c. District Commanders;

   d. Maintenance and Logistics Commanders;

   e. Group Commanders;

   f. Commanding officers; and

   g. Medical officers of the Uniformed Services

2. Supervisors or reporting officers of medical officers may not have medical boards convened on themselves at their own facility.

3. When a medical board is convened for a flag officer, Commander, Coast Guard Personnel Command (CGPC-c) and Commandant (G-C) shall be advised by FOUO (For Official Use Only) message.

C. Composition.

1. A medical board normally consists of two medical officers. The medical board may consist of one medical officer in exceptional circumstances, e.g., units with only one medical officer assigned or when another medical officer is not reasonably available. A clinical psychologist may be a medical board member when considering an evaluee with psychological impairments. A Coast Guard Physician's Assistant (PYA) may be a member, though not the senior member, of a medical board.

2. When an aviator or another member in an aviation rating is before the board, at least one board member shall be a flight surgeon. Any medical board prepared in the case of an aviator will be reviewed by a Coast Guard flight surgeon.

3.C.3. Whenever the record presents a medical condition or mental disorder in which mental competency is in question, a determination of mental competency shall be made. When sitting as a mental competency board, the medical board shall consist of three medical officers, one of whom is a board certified psychiatrist.

D. Requirement for Initial Medical Board (IMB). Existence of one or more of the following situations requires convening an IMB:

1. Detection of a physical impairment preexisting enlistment or appointment in the Coast Guard. (see chapter 12, Personnel Manual, COMDTINST M1000.6 (series));

2. Refusal of medical or dental treatment or diagnostic procedure. (see paragraph 2.C.8.);

3. After 60 continuous days of hospitalization (Saturdays, Sundays, and holidays included), or intermittent admission to an inpatient facility for the same diagnosis for 60 out of any 90 consecutive days. This consecutive period is computed exclusive of convalescent or sick leave, when such leave leads to a fit for duty status at the end of the leave period. If, at the end of the sick or convalescent leave, a readmission for evaluation of the same condition is required, the entire period of hospitalization and sick leave will be counted in computing the 90 days;

4. Failure to meet physical standards at the following times:

   a. required periodic physical examination (except for those conditions set forth in chapter 12, Personnel Manual, COMDTINST M1000.6 (series), e.g. obesity, motion sickness, erroneous enlistment, etc.).

   b. aviation physical examination of an enlisted member when the disqualification may lead to permanent removal from aviation.

5. After maximum hospital benefits have been attained and the member remains in a status other than fit for duty; after outpatient treatment in a hospital or a clinic when the total of all visits in a 1-year period exceeds 30 visits for other than treatment for traumatic conditions. The 30 visit limitation applies to those visits where the member sees medical personnel (Medical Officers, Physician Assistants, Health Service Technicians, etc.) or is referred to a civilian hospital or outpatient clinic.

6. For members retained on active duty under the authority of chapter 17, Personnel Manual COMDTINST M1000.6 (series), at least 6 months prior to expiration of the period of retention. There is no requirement for a reevaluation of disability when a member is retained for less than 6 months;

3.D.7. A member who is being processed for separation, or for retirement by reason of age or length of service, shall not normally be referred for physical disability evaluation. Unless previously retained on active duty under the provisions of chapter 17, Personnel Manual, COMDTINST M1000.6 (series), absence of a significant decrease in the level of a member's continued performance up to the time of separation or retirement satisfies the presumption that the member is fit to perform the duties of his or her office, grade, rank or rating. (see paragraph 2.C.2.); and

8. In any situation where fitness for continuation of active duty is in question.

E. Requirement For Disposition Medical Board (DMB). DMB's are convened as provided for under paragraph 4.A.7. and adhere to the format prescribed for IMBs.

F. General Procedure for Medical Boards.

1. A medical board considers and reports upon any evaluee whose case has been referred for consideration. It conducts a thorough physical examination to evaluate the member's general health. Additionally, all impairments noted shall be separately evaluated, in accordance with the "VA Physician's Guide for Disability Evaluation Examinations," including psychiatric examination when indicated. It shall obtain and examine available records to formulate a conclusion regarding the member's present state of health and the recommendations required.

2. A medical board is not a forum for conducting a formal hearing, taking other than medical evidence, or making determinations required of physical evaluation boards by chapters 4, 5, 6, and 7 of this manual. It presents a clear medical picture of the case in question making all pertinent diagnoses/prognoses and giving a medical opinion as to the evaluee's fitness for duty and recommendations for future action. A checklist is provided in exhibit 3-4 to aid in preparing the medical board.

G. Medical Board Reports.

1. Organization of the Board Report. An original and five copies of a medical board report shall be prepared, consisting of the following:

a. Medical Board Report Cover Sheet (NAVMED 6100/1) prepared by a Coast Guard Medical Officer, with all items completed, including ICDA codes for diagnoses listed;

b. Narrative Summary (SF-502) (typed);

3.G.1. c. Such additional statements and documents as may be required under paragraphs 3.H. and 3.I.;

d. Legible copies of all health record information pertaining to each diagnosed impairment or impairment listed in the evaluee's rebuttal, including current and enlistment or commissioning SF-88's and SF-93's, and reports of X-rays; and

e. If the medical board is for:

(1) a cardiac case, append EKG and American Heart Association Diagnostic Standards.

(2) an impairment of hearing, append audiometric examination and state the testing standard used (ASA, ISO, or ANSI) to include pure tone audiometry and speech discrimination without hearing aids.

(3) high blood pressure or hypertension, append the results of a 3 day serial blood pressure check taken twice a day while on medication.

(4) diabetes mellitus, state the types and dosage of prescribed medications.

2. Quality of the Board Report. The importance of a legible, complete report cannot be emphasized too strongly, since this report is the basis for all further action in the case. Pertinent consultations, in particular, shall be presented in typewritten form.

3. Preparing the Narrative Summary (SF-502).

a. The Narrative Summary shall present a summary of the pertinent data concerning each complaint, symptom, disease, injury or disability presented by the evaluee, which causes or is believed by the medical board to cause impairment of the evaluee's physical condition. In presenting its summary, the board shall

(1) set forth accurate and fully descriptive information, in the format of exhibit 3-1;

(2) whenever practicable, indicate impairment of functions in terms of objective tests or findings rather than as opinions, conjecture, or speculation. The discussion of any impairment shall show the limitation of activity imposed by physical impairments; disease; injury to any organ, system, or part; and the significance of symptoms

3.G.3. a. (2) (cont'd) causing impairment. In a case of ankylosis or limitation of motion, the angle of the affected joint and motion limitation shall be stated in quantitative terms consistent with the VASRD;

(3) set forth data to permit a reviewer to conclude whether the evaluee suffers impairment of health in any respect, and the degree thereof. Such evidence is needed for use in rating disabilities in the event the evaluee is later found to be unfit to perform the duties of grade or rating. All evidence bearing upon the permanent or temporary character of impairment of any organ, sys-tem, or part shall be completely set forth;

(4) should no limitation of physical activity exist, so state;

(5) in all cases where mental disorders are diagnosed or other appropriate circumstances exist, the medical board shall

(a) give an opinion as to whether disclosure to the evaluee of information relative to the evaluee's physical or mental condition would or would not be deleterious to the evaluee's physical or mental health;

(b) indicate whether, if discharged into his or her own custody, the evaluee will or will not constitute a danger to him or her self or to others;

(c) indicate whether the evaluee is or is not likely to become a public charge; and

(d) indicate whether the evaluee is or is not mentally competent to conduct his or her personal affairs. (see paragraph 3.C.3.)

b. The medical board report shall neither assign a percentage rating nor make reference to the VASRD rating codes.

c. Every Narrative Summary shall be reviewed and commented upon by a Coast Guard Medical Officer.

4. Recommendation of an IMB.

a. Based on the physical condition found, the IMB shall recommend one of the following dispositions:

(1) Disposition not requiring follow-up action: meets physical retention standards and is either

3.G.4.a.(1) (a) medically fit for duty; or

(b) medically fit for duty (aviation or diving).

(2) Dispositions which may lead to separation from the Service:

(a) unfit for continued duty because of possible physical impairment, referral to the CPEB;

(b) unfit for continued duty for reasons other than physical impairment; or

(c) unfit for continued duty because of physical impairment that existed prior to entry but was not aggravated by service.

b. Findings of unfit for continued duty may be accompanied by one of the following recommendations:

(1) limited duty. Indicate time limitation, not to exceed 6 months, and recommended limitations;

(2) outpatient or inpatient treatment. Indicate time limitation, normally not to exceed 6 months; or

(3) outpatient treatment or limited duty not to exceed 6 months during which either control of aircraft, participation in flight, or diving is prohibited.

c. If the IMB's recommendation is that of paragraph 3.G.4.b.(3) above, a 6 month composite time limit is placed on the IMB's recommendations of continued inpatient and outpatient treatment, limited duty, or any combination thereof. This time limit will commence when the IMB report is dated. Recommendations can be for periods less than 6 months.

5. Recommendation of a DMB. The DMB shall make a recommen-dation as prescribed for an IMB in paragraph 3.G.4.

6. Preparing the Medical Board Cover Sheet (NAVMED 6100/1). Items on the NAVMED 6100/1 (Rev. 10-83) which are not self-explanatory shall be prepared as follows: (see exhibit 3-2)

a. Item 1.

(1) From: Enter name and address of the facility where the medical board was held.

3.G.6. a. (2) To: Enter Commander (CGPC-adm), Coast Guard Personnel Command.

(3) Via: Enter evaluee's commanding officer.

b. Item 2. Enter the evaluee's last name, first name, and middle initial.

c. Item 3. Enter the official name and address of the duty station to which the member is permanently attached. For second and subsequent boards, note present duty station but also indicate, under remarks, the member's duty station when the initial board was held.

d. Item 4. Self-explanatory.

e. Item 5.

(1) Indicate sex, "M" or "F."

(2) Leave blank.

f. Item 6. Enter numeric date, month (spelled out), and calendar year of birth of member (e.g., 07JUL60).

g. Item 7. Enter length of service in years and months. All active duty service in all U.S. Uniformed Services shall be counted.

h. Item 8.

(1) Grade/Rate. Enter the evaluee's grade or rate abbreviation, e.g., LT or YN2.

(2) Branch. Enter either USCG or USCGR.

(3) Designator/MOS. Leave blank.

i. Item 9. If the condition entered as item 18A (Primary Diagnosis) is not the result of an accident, violence, or poisoning, enter "Not Applicable"; otherwise enter one of the following:

(1) Battle casualty - (self-explanatory);

(2) Motor vehicle - (includes automobile and motor-cycle accidents);

(3) Falls - (includes falls either on the same or different levels on land or ships);

3.G.6. i. (4) Recreation - (includes cases involving injuries resulting from participation in sports, and other recreational activities not organized by the Coast Guard, and those resulting from Coast Guard organized recreation activities, whether for training purposes or not);

(5) Assault by another - (includes cases involving injuries received as a result of fighting or attack by another person);

(6) Self-inflicted - (includes cases involving both accidental and intentional self-inflicted wounds); and

(7) Other external cause - (includes cases involving accidents, violence, or poisoning with causes not classifiable above).

j. Item 10. Enter the military theater of operation to identify the geographic origin of the disease or injury and indicate whether or not the condition for which the medical board was held was a result of hostile or non-hostile action.

(1) Enter abbreviation of country followed by "H" (Hostile) or "NH" (Non-hostile), for example: VNH for Vietnam, hostile.

(2) Enter "NA" if not applicable.

k. Item 11. Next to "Other" indicate USCG. Record a "5" in the box.

l. Item 12. Complete only if member has less than 1 year of active service.

m. Item 13. Enter the date of expiration of active obligated service. For officers enter "INDEFINITE" if applicable. n. Item 14. Leave both 14a. and 14b. blank.

o. Item 15. Enter date the board met, NOT the date of the report. If a DMB - enter the date of the previ-ous IMB preceded by the letter "I" and the date of the DMB preceded by the letter "D."

p. Item 16. EPTE - Existed Prior to Entry, DNEPTE - Did Not Exist Prior to Entry (see paragraphs 2.A.23. and 2.C.3.)

3.G.6. p. (cont'd) [Note: If EPTE, specific documentation is required in the Narrative Summary and/or command endorsement, to include all relevant hospital or outpatient records, and physician's records supporting the EPTE determination. (see paragraph 3.G.6.s.(3))]

q. Item 17. Place an "X" in the appropriate box if the Line of Duty (LOD) investigation has been completed by the cognizant command. If the investigation has not been completed, enter the name of the command in the remarks section with amplifying information as to the projected completion date.

r. Item 18. Place an "X" in the appropriate box. Enter the name of the command processing this action in the remarks section. Where "YES" is indicated, the board must be forwarded for administrative review.

s. Item 19A-F.

(1) General. Information on established diagnoses related to the medical board are needed, not only for legal reasons, but also for planning and evaluation purposes by the Commandant. The diagnostic nomenclature to be used in recording these diagnoses will be based on and consistent with current medical terminology. International Classification of Diseases (ICD) and Diagnostic and Statistical Manual of Mental Disorders (DSM), current editions, shall be utilized for establishing diagnoses. When recording the diagnoses, care should be taken to make them as complete and definite as possible. Vague and general expressions are to be avoided.

(2) Order of Diagnoses. Space has been reserved for recording six diagnoses. The first diagnosis listed-PRIMARY DIAGNOSIS-should be the major diagnosis or condition for which the medical board was convened. Where there is more than one diagnosis or condition to be recorded, the following rules apply:

(a) If the diagnoses are unrelated, the primary should be the most significant;

(b) If there is a combination of related causes, the primary diagnosis should be the one which was determined to be the precipitating factor for the other diagnosis or diagnoses. For example, in a diagnosis of "schizophrenic reaction acute, undifferentiated type due to

3.G.6.s.(2) (b) (cont'd) drug ingestion, LSD and Mescaline," the diagnosis "drug ingestion" will be considered the primary diagnosis;

(c) The second through the sixth diagnoses should be recorded in order of importance.

(3) EPTE Origin. From item 16, enter the appropriate number in the box provided for the origin of each diagnosis entered.

t. Item 20. Enter recommended disposition in accordance with paragraphs 3.G.4. or 3.G.5. Disposition number 8 is not applicable to the Coast Guard.

u. Item 21. Indicate the YR/MONTH/DATE that the period of limited duty automatically expires. Compute expiration date from the date the physician conducts the examination upon which the board is dictated. This section may be used when considered necessary by the board. When the indicated disposition is limited duty, the board shall set forth the major physical limitations imposed by the member's condition and the length of time that the member should be retained in a limited duty status, e.g., "no heavy lifting or bending - 6 months."

v. Item 22. Type the name, grade, corps, and branch of service of each member. Signatures of each member shall appear in the space provided. Indicate a psychiatrist by placing a (P) after the typed name. Indicate a clinical psychologist by placing a (CP) after the typed name. Facsimile signature stamps shall not be used. Copies of medical board reports submitted for review or action must include one signed copy.

w. Item 23. Self-explanatory.

x. Item 24. See paragraph 3.I.

y. Item 25. When a member is found fit for duty after the initial period of limited duty, the preparing physician shall ensure that the remainder of the form is completed. Examination findings, to include residual effects, shall be recorded on an SF 600. The Summary findings, fitness for duty, and date returned to full duty, shall be recorded in this item.

(1) Type the examining physician's name, grade, corps, and Service. The physician signs and provides date signed.

3.G.6.y. (2) Type member's name, grade, rate, and Service. Once the member signs and provides the date signed, the member has acknowledged that he or she has been counseled and understands the finding of fit for full duty.

(3) Type the name of the directorate or head of department, grade, corps, and Service. Obtain both signature and date.

z. Item 26. Indicate activity to which the member has been transferred to await final action.

H. Evaluee Notification.

1. Unless it is considered that the information contained in the board's report might have an adverse effect on the evaluee's physical or mental health:

a. the evaluee shall be furnished a copy of the board's report;

b. significant findings and opinions and recommended disposition shall be brought to the evaluee's attention; and

c. the PDES shall be explained and the evaluee shall be counseled by a qualified (knowledgeable) person.

2. Complete the Patient's Statement Regarding the Findings of the Medical Board, CG-4920 (exhibit 3-3), and refer it to the evaluee for signature. This form shall accompany the board's report (IMB or DMB). If the medical board has been prepared in an Army or Air Force facility, completion of CG-4920 is not required: DA Form 3947 and AF Form 618 are considered suitable substitutes. NAVMED 6100/2 is not a suitable substitute because it does not list the diagnoses.

3. The evaluee shall be afforded an opportunity to submit a statement in rebuttal to any portion of the board's report. If the evaluee submits a rebuttal, the board shall, if practicable, review the rebuttal and make changes to the report or prepare additional comments, as deemed appropriate. A copy of any changes or comments will be provided to the member. If the evaluee has not acted within 15 working days after notification of the board's findings and recommended disposition, the action indicated in paragraph 3-I shall proceed without further delay.

4. An evaluee may submit a letter to Commander (CGPC-opm) or (CGPC-epm), Coast Guard Personnel Command, requesting retention on active duty, pursuant to the provisions of article 6-B-4 and chapter 17, Personnel Manual, COMDTINST M1000.6 (series). This letter request shall be forwarded

3.H.4. (cont'd) together with the IMB or DMB to Commander (CGPC-adm), Coast Guard Personnel Command.

5. An evaluee who is in receipt of normal service retirement orders must elect, in writing, whether to be processed for a physical disability retirement or to comply with the normal service retirement orders. Article 12-C-3, Personnel Manual, COMDTINST M1000.6 (series) provides further guidance in this regard.

I. Action by the Evaluee's Commanding Officer.

1. Convene, or request the convening of, a medical board in accordance with paragraph 3.D. when there is doubt concerning a member's physical ability to perform his or her duties of office, grade, rank or rating. If a retirement physical has disclosed the impairment for which a medical board is convened, notify the Coast Guard Personnel Command (CGPC-opm) or (CGPC-epm) and (CGPC-adm) immediately, in accordance with article 12-C-3, Personnel Manual, COMDTINST M1000.6 (series).

2. Upon receipt of the medical board report from a Military Treatment Facility (MTF), ensure the board includes all items required by paragraph 3.G.

3. Provide the evaluee a copy of the board, unless it has been determined by competent medical authority that disclosure of the contents of the medical board might adversely affect the evaluee's physical or mental health.

4. Ensure the evaluee is counselled about the contents of the board report, and a physician has provided the evaluee a thorough explanation of his or her medical condition, subject to the restrictions of paragraph 3.I.3. above.

5. Have the evaluee sign the CG-4920.

6. Attach the CG-4920 to the medical board.

7. Endorse the report of a medical board with a full recommendation based on knowledge and observation of the member's motivation and ability to perform. The endorse-ment shall be a summary of the duties normally associated with the office, grade, rank or rating of the evaluee and the evaluee's currently assigned duties, and it shall include a statement as to the evaluee's ability to perform these duties. It is imperative that all factors of duties of grade/rate affecting the health of the evaluee be properly documented and included in the medical board or the endorsement so that the CPEB may make the proper disposition of the case. Include a current telephone number where evaluee may be reached.

3.I.8. Establish an interim duty status for members during PDES processing in accordance with paragraph 3.J, and include that status in the endorsement.

9. Distribute the medical board report in accordance with paragraph 3.K.

10. Carefully screen medical boards disclosing conditions existing prior to entry. Should it appear there may have been a fraudulent enlistment, the record shall be forwarded to Commander (CGPC-adm), Coast Guard Personnel Command, via the chain of command.

11. In cases involving injury, append one of the following documents to the record. The evaluee's present commanding officer is responsible for obtaining this documentation and including it with the report of medical board even though the injury may have been sustained elsewhere.

    a. A copy of the investigative report if available, including action of the final reviewing authority, (see Coast Guard Administrative Investigations Manual, COMDTINST M5830.1 (series)); or

    b. A copy of the Injury Report, CG-3822, if line of duty and misconduct findings are favorable; or

    c. A concise statement executed by the evaluee's commanding officer, setting forth the time, place, and other circumstances surrounding the injury, accompanied by an opinion as to line of duty/misconduct.

12. In cases involving a member of the Coast Guard Reserve, also append a copy of Disability Orders and Notice of Eligibility for Disability Benefits (NOE), CG-4671, or other evidence that the evaluee's illness/injury was incurred while entitled to receive basic pay.

13. When the medical board finds an evaluee to be afflicted solely by a personality or intelligence disorder or other impairment not a disability within the meaning of the law (see listings in paragraph 2.A.7. and in chapter 5, Medical Manual, COMDTINST M6000.1 (series)), the following applies:

    a. if the evaluee's commanding officer concurs with the medical board report, the case will be processed in accordance with the administrative discharge procedures set forth in chapter 12, Personnel Manual, COMDTINST M1000.6 (series); or

3.I.13. b. if the evaluee's commanding officer does not concur with the medical board report, or has any doubt concerning their findings and recommendations, the commanding officer will forward the original and two copies, with appropriate endorsement, to Commander (CGPC-adm), Coast Guard Personnel Command.

14. When the evaluee has requested retention as provided in paragraph 3.H.4. above, the evaluee's commanding officer will endorse the letter request in accordance with Article 6-B-4.f.(2) or chapter 17, Personnel Manual, COMDTINST M1000.6 (series) and forward the request and all endorsements together with the medical board report to Commander (CGPC-adm), Coast Guard Personnel Command.

J. Change in Evaluee's Status or Physical Condition Prior to Final Action. When there is any significant change in the evaluee's status or physical condition prior to final action, Commander (CGPC-adm), Coast Guard Personnel Command, and Commander (CGPC-opm) or (CGPC-epm), Coast Guard Personnel Command, as appropriate, shall be notified by the evaluee's commanding officer.

K. Distribution of Medical Board Reports. Medical board reports shall be signed by all of the members of the board and distributed as follows:

1. original and two copies to Commander (CGPC-adm), Coast Guard Personnel Command;

2. copy to member's health record;

3. copy to evaluee; and

4. copy to convening authority's files.

Commander (CGPC-adm), Coast Guard Personnel Command will acknowledge receipt of the medical board report if it is accompanied by an Acknowledgment/Referral Card, CG-4217.

L. Assignment of Personnel Awaiting Final Action of Medical Boards. The commanding officer establishes the interim duty status of members being processed within the Physical Disability Evaluation System, taking into consideration medical recommendations when available. A message report showing the assigned status shall be sent to Commander (CGPC- opm) or (CGPC-epm), Coast Guard Personnel Command, as appropriate. One of the following actions shall be taken:

1. Full Duty/Limited Duty. When full duty or limited duty pending disposition of the case is appropriate, the evaluee shall be assigned to such duty if the evaluee's services can be used effectively without detriment to physical or mental health, or to unit operations.

3.L.2. Continued Medical Treatment/Sick Leave. When continued medical treatment is recommended, an evaluee who at the time is hospitalized will be retained under treatment. When hospitalization is no longer necessary, either sick leave (see the Personnel Manual, Chapter 7, COMDTINST M1000.6 (series)) or limited duty apply, and the evaluee shall receive necessary follow-up care. Care from civilian sources shall be obtained in accordance with the Medical Manual, COMDTINST M6000.1 (series).

M. Expedited Review Cases. In those cases (whether or not a medical board has been held) where the member is so gravely injured or ill that the prognosis is "imminent death," the normal disability separation process shall be expedited as provided in chapter 4.

N. Coast Guard Personnel Command Action on Medical Board Reports. On receipt of a technically correct (contains all required enclosures, properly completed and signed) medical board report, Commander (CGPC-adm-1), Coast Guard Personnel Command will refer the medical board report to the CPEB for action in accordance with chapter 4.

MEDICAL BOARD NARRATIVE SUMMARY FORMAT

1. If, in the board's opinion, the evaluee is Not Physically Qualified, use the following format:

This _____(a)_____ year old, _____(b)_____ handed, _____(c)_____ _____(d)_____ approximately _____(e)_____ and _____(f)_____ of active military service, was evaluated on an _____(g)_____ basis at this facility for the purpose of and Initial/Disposition Medical board, with the diagnosis(es) of _____(h)_____.

According to a review of health record, systems, and social and family histories, the evaluee was well until _____(i)_____ when _____(j)_____. Physical examination revealed _____(k)_____ were within normal limits except for _____(l)_____.

Indicated laboratory studies, including _____(m)_____ were within normal limits except _____(n)_____.

Treatment consisted of _____(o)_____ and _____(p)_____.

The physical examination shows _____(q)_____.

It is the opinion of the board that the diagnosis(es) of _____(r)_____ is/are correct and that the patient is _____(s)_____.

The prognosis for this patient is _____(t)_____.

The patient is expected _____(u)_____.

The additional treatment recommended is _____(v)_____.

There is/are no disciplinary action(s) pending. _____(w)_____.

Personal appearance of the evaluee before a FPEB would/should not be deleterious to the patient's physical or mental health.

Disclosure to the evaluee of information relative to his/her physical or mental condition would/should not be deleterious to that condition. If discharged into one's own custody, the evaluee will/will not constitute a danger to self or the public safety

The evaluee is/is not likely to become a public charge.

Exhibit 3-1

MEDICAL BOARD NARRATIVE SUMMARY FORMAT (cont'd)

KEY:

(a) Evaluee's age
(b) Major hand
(c) Evaluee's race
(d) Evaluee's sex
(e) Years service
(f) Months service
(g) Outpatient/Inpatient, as appropriate
(h) Original diagnosis(es)
(i) Date of onset of problem
(j) Symptoms and complaints of present illness or circumstances of injury
(k) Specify physical findings within normal limits
(l) Significant physical findings
(m) List laboratory studies conducted that were within normal limits
(n) List positive laboratory studies
(o) Outline treatment provided
(p) Present subjective findings
(q) Present objective findings
(r) Diagnosis(es)
(s) Specific manner in which evaluee is unable to perform duties or normal activities.
(t) State prognosis of the evaluee's impairment according to accepted medical principles
(u) "To be fit for full duty in (state time frame)" "To never be fit for full duty," as appropriate
(v) State recommended further treatment or therapy
(w) Inpatient only, enter: "Maximum benefits of hospitalization have been achieved," or "Maximum benefits of hospitalization have not been achieved. Further treatment and care is required and the evaluee is to be transferred to the Veterans Administration Hospital nearest his/her home," as appropriate.

2. If, in the board's opinion, the evaluee is Fit for Duty, the format will be like that for Not Fit for Duty with the exception that nothing follows the statement of opinion, and the statement of opinion shall read as follows:

It is the opinion of this board that the diagnosis(es) or (q) is/are correct. The evaluee does not have a physical impairment that precludes performing the duties of grade or rate.

Exhibit 3-1 (cont'd)

MEDICAL BOARD REPORT COVER SHEET — **PREPARATION INSTRUCTIONS** SEE MANMED ARTICLE 18-26 — Report Symbol MED 6100-1

1. FROM: COMMANDING OFFICER, CG SUPRTCEN PORTSMOUTH TO: COMMANDER (MPC-sep), MILITARY PERSONNEL COMMAND VIA: COMMANDING OFFICER, USCGC INGHAM (WHEC 35)	2. NAME (Last, First, Middle Initial): NOBLES, CHARLES GOLF 3. DUTY STATION: USCGC INGHAM (WHEC 35) 4. SOCIAL SECURITY NO.: 123 45 6789 — 5a. SEX: M — 5b. RACE: — 6. DATE OF BIRTH: 13 DEC 52
7. LENGTH OF SERVICE: 20 years 10 months — 8. GRADE/RATE: YNCS — BRANCH: USCG — DESIG/MOS: — 9. CAUSE OF INJURY: — 10. MILITARY THEATER OF OPERATIONS: N/A	
11. MEMBER'S STATUS (Record in Block): 1. ACTIVE DUTY NAVY; 2. ACTIVE DUTY NAVY RECRUIT; 3. ACTIVE DUTY MARCORPS; 4. ACTIVE DUTY MARCORPS RECRUIT; 5. OTHER -USCG [5] — 12. DATE AND PLACE OF ENTRANCE PHYSICAL EXAMINATION (If less than 1 year svc) DATE: PLACE: — 13. EAOS/AOS: 18 AUG 97 — 14a. ADMITTED TO SICKLIST YES ☐ NO ☐ — 14b. DATE OF DISPOSITION (Yr/Month/Date)	
15. DATE OF BOARD (Year/Month/Day): 04 SEP 94 — 16. EPTE (Origin): 1. EPTE-AGGRAVATED BY SERVICE; 2. EPTE NOT AGGRAVATED BY SERVICE; 3. DNEPTE — 17. LOD INVESTIGATION YES ☒ NO ☐ — 18. DISCIPLINARY ACTION PENDING YES ☐ NO ☒	
19A. PRIMARY DIAGNOSIS (Indicate EPTE/Origin): DIABETES MELLITUS (INSULIN DEPENDENT) #250.03 EPTE ☐	19B. SECOND DIAGNOSIS ☐
19C. THIRD DIAGNOSIS ☐	19D. FOURTH DIAGNOSIS ☐
19E. FIFTH DIAGNOSIS ☐	19F. SIXTH DIAGNOSIS ☐
20. INDICATED DISPOSITION: 1. REFER TO CPEB; 2. DISCHARGE PHYSICAL DISABILITY; 3. DISCHARGE ENLISTED IN ERROR; 4. DISCHARGE COG; 5. FULL DUTY; 6. FIRST PERIOD LIMDU; 7. SECOND PERIOD LIMDU; 8. DEPT REVIEW ☐	
21. REMARKS (Year/Month/Day) — LIMITED DUTY AUTOMATICALLY EXPIRES ON — LIMITATIONS ARE	

22. BOARD MEMBERS		GRADE/CORPS	SERVICE	SIGNATURE
Senior Member	J.J. JONES	CAPT	USPHS	
Member	I. A. SALTY	CAPT	USPHS	
Alternate Member or Psychiatrist				

23. ENCLOSURES: ☐ SIGNED NAVMED 6100/2; ☐ SIGNED NAVMED 6100/3; ☐ MEMBER'S REBUTTAL; ☐ COPY OF HEALTH RECORD; ☒ LINE OF DUTY INVESTIGATION; ☐ OTHER SPECIFY

24. CONVENING AUTHORITY ACTION

APPROVED: YES/NO. ADMINISTRATIVE INVOLUNTARY SEPARATION IS/IS NOT PENDING.

DATE	CONVENING AUTHORITY	GRADE/CORPS	SERVICE	SIGNATURE
15 OCT 94	T.M. EDWARDS	CAPT	USCG	

25. MEMORANDUM ENDORSEMENT UPON REEVALUATION (Year/Month/Day)

A. MEMBER EXAMINED THIS DATE THE RESULTS AND FINDINGS ARE

B. MEMBER COUNSELED THIS DATE OF THE FINDING OF FIT FOR FULL DUTY — Yr Mo Day

DATE	EXAMINING PHYSICIAN	GRADE/CORPS	SERVICE	SIGNATURE
DATE	MEMBER	GRADE/RATE	SERVICE	SIGNATURE*
DATE	DIRECTORATE/HEAD OF DEPARTMENT	GRADE/CORPS	SERVICE	SIGNATURE

*BY SIGNATURE MEMBER ACKNOWLEDGES AND UNDERSTANDS THE FINDING OF FIT FOR FULL DUTY.

26. MEMBER TRANSFERRED TO _____ AWAITING FINAL ACTION

NAVMED 6100/1 (Rev. 10-83) — S/N 0105-LF-206-1006

Exhibit 3-2

Commanding Officer, USCG Support Center, Portsmouth
(Medical Facility)

PATIENT'S STATEMENT REGARDING THE FINDINGS OF THE MEDICAL BOARD

I, CHARLES GOLF NOBLES, am hereby informed that the medical board of 4 SEP 94 *(Date)* convened in my case made the following findings:

DIAGNOSES:

(1) DIABETES MELLITUS (INSULIN DEPENDENT)
(2)
(3)
(4)

RECOMMENDATIONS:

☐ Fit for Duty

xx☒ Not Fit for Duty because of physical disability, refer to CPEB

☐ Not Fit for Duty for reasons other than physical disability

☐ Fit for Limited Duty for a period of _____ with the following limitations: _____

I feel that all my impairments have been evaluated adequately by the Medical Board, and that these diagnoses (listed above) will be considered by the CPEB, for its independent evaluation.

I understand that the medical board's report with my rebuttal, if any, will become part of my official record.

I further understand that the Medical Board's opinions and recommendations are not binding on the Coast Guard and that my case will be subjected to review and final disposition by higher authority.

PATIENT MUST EXECUTE STATEMENT 1 OR 2

1. I do not desire to submit a statement in rebuttal to the above findings and recommendations.

Charles G. Nobles 30/Sept 94
CHARLES G. NOBLES *(Signature of Patient/Date)*

John Doe 30/Sept 94
JOHN DOE, HSC, USCG *(Signature of Witness/Date)*

2. I desire to submit a rebuttal to the above findings and recommendations, which will become part of my official records.

_____ *(Signature of Patient/Date)*

_____ *(Signature of Witness/Date)*

DEPT. OF TRANSP., USCG, CG-4920 (REV. 1-81) SN 7530-00-FO2-2470
PREVIOUS EDITION IS OBSOLETE

Exhibit 3-3

MEDICAL BOARD CHECKLIST

Refer to Chapter 3, COMDTINST M1850.2 (series), for details.

MEDICAL BOARD REPORT. Include the following:

1. **[ ] Cover Sheet (NAVMED 6100/1).**

   Note: A Coast Guard Physician, if one is available, shall prepare the cover sheet. If a DoD cover sheet has been prepared, it may also be included in the report package.

2. **[ ] Narrative Summary (SF-502) (typed).**

3. [ ] Copies of all **health record information pertaining to each diagnosed impairment**, including SF-88 and SF-93 (current and enlistment or commissioning physical exams), consultations, reports of X-rays, photographs, and video tapes, when appropriate. (All reports, including consultations, must be typewritten or printed legibly)

4. In **Cardiac Cases:**
   [ ] EKG, and
   [ ] American Heart Association Diagnostic Standards.

5. In **impairment of hearing cases:**
   [ ] Audiometric Examination,
   [ ] Statement as to testing standard used (ASA, ISO, or ANSI), and
   [ ] Voice discrimination test results: pure tone audiometry and speech discrimination without hearing aids.

6. In **high blood pressure (hypertension) cases:**
   [ ] Results of 3 day serial blood pressure check taken twice a day while on medication.

7. In **diabetes mellitus cases:**
   [ ] Type and frequency of medications administered and observed results.

8. In **Brain surgery cases:**
   [ ] Size of hole in skull.

COMMAND ACTION.

1. **Advise member** of all the following:
   [ ] significant findings, opinions and recommendations;
   [ ] opportunity to comment on report;
   [ ] opportunity to submit a letter requesting retention;
   [ ] requirement to sign CG-4920 or bottom section of DA Form 3947 or AF form 618, as appropriate, within 15 working days;

MEDICAL BOARD CHECKLIST

2. [ ] **Establish interim duty status for member.**

3. [ ] **Send message reporting assigned status** to MPC-opm or MPC-epm.

4. For **injury cases**, provide one of the following:
   [ ] copy of the investigative report, **or**, preferably
   [ ] copy of the Injury Report (CG-3822), **or**
   [ ] CO's statement setting time, place and other circumstances surrounding the injury, accompanied by an opinion as to line of duty and misconduct.

   Note: The member's current command is responsible for providing an opinion as to misconduct or line of duty, even if the injury occurred elsewhere.

5. **Attach the following to the Board package** (where applicable):
   [ ] member's comments regarding the board's report;
   [ ] member's request for retention with CO's endorsement;
   [ ] if member is a Reservist, a copy of the NOE (CG-4671) or other evidence that the impairment was incurred while entitled to receive basic pay.
   [ ] if member is in receipt of normal service retirement orders, the member's election in accordance with Article 12-C-3.b. of COMDTINST M1000.6 (series).

6. [ ] **Endorse board.**

   Note: If the board recommends fit for duty, and the command concurs, the statement, "I concur with the board," will suffice. However, if the board recommends not fit for duty, comply with paragraph 3-I-7 of COMDTINST M1850.2 (series).

7. **Distribute the board package** as follows:
   [ ] original and two copies to Commander, MPC-adm-1 (no via addressees);
   [ ] a copy to the member; and
   [ ] a copy retained by convening authority.

MEMBER ACTION.

1. **Required**—complete one of the following:
   [ ] CG-4920, if cover sheet is NAVMED 6100/1; or
   [ ] bottom portion of DA form 3947; or
   [ ] bottom portion of AF form 618.

2. **Optional:**
   [ ] comment, in writing, on board report.
   [ ] submit a letter requesting retention.

Exhibit 3-4 (cont'd)

CHAPTER 4

CENTRAL PHYSICAL EVALUATION BOARD (CPEB)

CONTENTS

CHAPTER 4. CENTRAL PHYSICAL EVALUATION BOARD (CPEB)

A. Policy Governing the CPEB.

1. Purpose. The CPEB is a permanently established administrative body convened to evaluate the following on the basis of records only:

   a. the fitness for duty of active duty and reserve members;

   b. the fitness for duty of members currently on the Temporary Disability Retired List (TDRL).

2. Convening Authority. Commander (CGPC-c), Coast Guard Personnel Command assigns members to serve on the CPEB by precept. Commandant (G-CCS) assigns members to serve on the CPEB by precept when the evaluee is a flag officer.

3. Authority. The CPEB evaluates the fitness for duty of all evaluees whose cases are referred to it for consideration by Commander (CGPC-adm), Coast Guard Personnel Command.

4. Quorum of the CPEB. A CPEB shall consist of a panel of at least two commissioned officers, one of whom serves as President and the other as medical member.

   a. A commissioned officer on active duty in the Coast Guard or Coast Guard Reserve, serving in pay grade O-5 or above shall be designated by the CPEB precept as permanent President. The precept may also designate other members as alternate Presidents who shall act for the President upon request of the permanent President. When practicable, the President serving on the panel shall be senior to the evaluee.

   b. When the evaluee is a Reservist, one of the CPEB members shall be a Reservist, senior to the evaluee when practical.

   c. The medical member shall normally be a medical officer (physician) assigned to the Coast Guard. The medical member shall not have participated in the medical board or treated the evaluee for the matter under consideration.

   d. A nonvoting recorder shall normally be assigned.

5. Duties of the Members. It is the duty of each member of a CPEB to weigh and to impartially examine all relevant evidence in a case, and make findings and recommendations in conformity with applicable laws, regulations, and established policy. Each member has an equal voice and vote with other members in deliberating upon and deciding

4.A.5. (cont'd) all questions submitted to vote. Members of the board may discuss the case freely in closed session. No disclosure shall be made of the opinions expressed by any member.

6. Unanimity of Members. The findings and recommended dispo-sition of a CPEB panel shall be unanimous. If the members cannot agree, the case will be forwarded to the FPEB for consideration.

7. Disposition Medical Board (DMB). After reviewing the medical board record, if the CPEB determines the evidence is insufficient for the CPEB panel to make a judgment as to fitness for duty or to rate impairments, the CPEB may order a DMB. DMB actions will normally be completed in such time as specified by the CPEB. DMB's shall be prepared in the format prescribed for IMB's.

8. CPEB Evaluation/Reevaluation of Members on the Temporary Disability Retired List (TDRL). The CPEB shall consider each periodic physical evaluation report following examina-tion of an evaluee on the TDRL. The CPEB will continue on the TDRL an evaluee whose intermediate (not final) periodic evaluation indicates that the evaluee's disability is not permanent, is rated at 30 percent or greater, and the evaluee remains unfit for continued duty. In a case where the periodic physical evaluation report indicates the evaluee is fit for duty or that the evaluee's condition is permanent or the degree of disability is less than 30 per-cent, the CPEB will make findings and recommend a disposi-tion.

9. Required Findings and Recommended Disposition of CPEB.

   a. When the CPEB considers an active duty member's case, it shall make findings and recommend a disposition in accordance with paragraphs 2.C.3.a. and 2.C.3.b.

   b. When the CPEB considers the case of a member on the TDRL, it shall make findings and recommend a disposition in accordance with paragraph 2.C.3.c.

10. Expedited Review Cases. Laws relating to the retirement or separation of military personnel because of physical disability were enacted primarily to maintain a vital and fit military organization. These laws were designed to provide for the retirement or separation of members determined to be unfit to perform the duties of their office, grade, rank, or rating because of physical disability. Since retirement provides special benefits, a member in danger of imminent death, if possible, should not be denied benefits that a survivor with disabilities would receive. The Coast Guard has no legal authority to retroactively retire members who have already died. Neither is it permissible for the Coast Guard to evaluate the disabilities of members

4.A.10. (cont'd) whose prognosis is imminent death by standards which differ materially from those employed for all other members.

a. The essential elements that comprise any disability evaluation and that must be adhered to even in cases involving imminent death are as follows:

(1) command action to initiate evaluation (ordinarily by convening and/or endorsement of a medical board);

(2) medical recommendation regarding fitness for duty, diagnosis and prognosis (essentially, an initial medical board);

(3) determination of fitness or unfitness and rating of any disabilities by a physical evaluation board;

(4) assignment of legal counsel and counseling of evaluee;

(5) acceptance or rejection of the findings and recommended disposition of the evaluation board by the evaluee or on behalf of the evaluee by legal counsel or other legal representative;

(6) review of CPEB findings and recommended disposition for legal sufficiency; and

(7) action by the Final Approving Authority.

b. While the disability evaluation process cannot be altered, the process can be expedited. When an active duty member is so gravely injured or ill that the prognosis is imminent death, a commanding officer may notify the CPEB of that determination and request an expedited review. The expedited review of an imminent death case will speed the CPEB's receipt of the medical information, command input to the process, and the CPEB findings and recommended disposition.

[NOTE: AN EXPEDITED REVIEW UNDER THIS SECTION CANNOT BE INITIATED WITHOUT A SPECIFIC COMMANDING OFFICER REQUEST.]

c. A command request for expedited review shall be initiated via telephone to the Flag Plot Duty Officer at Coast Guard Headquarters. Telephone notification shall be followed-up with a PRIORITY precedence message addressed to Commander (CGPC-adm), Coast Guard Personnel Command. The message shall contain the following information:

4.A.10. c. (1) member’s full name, grade/rating, social security number, duty status, location of records;

(2) dependency status with name and address of spouse, name(s) and age(s) of all dependents, and their address(es) if different than spouse;

(3) status of member’s Survivor Benefit Plan elections, Record of Emergency Data designations, and SGLI amount and beneficiaries;

(4) length of active duty service for retirement purposes;

(5) life expectancy (hours or days);

(6) diagnosis and prognosis; (Include treatment being provided, member’s condition, treating physician’s and hospital’s name and telephone number);

(7) name and telephone number of the on-scene coordinator assigned to assist the PDES legal counsel (see paragraph 4.A.10.e.); and

(8) if death is imminent as a result of an injury or abnormal circumstance as opposed to a disease or illness, the following additional information is required:

(a) duty status at time of accident;

(b) brief description of circumstances of accident or incident;

(c) results of blood-alcohol/drug test(s), when taken, who administered test(s) and location of results; and

(d) CO’s determination of Line of Duty/Misconduct.

[NOTE: This message report is not a substitute for, but will normally follow, the report of personnel casualty required by article 11-A-2, Personnel Manual, COMDTINST M1000.6 (series). The two reports may be combined where a separate casualty report has not previously been submitted. If combined, Commander (CGPC-adm), Coast Guard Personnel Command shall be an info addressee. If a CPEB or FPEB has been previously held, that fact will be noted in the message report.]

4.A.10. d. In any case where review is being expedited, the Medical Board Cover Sheet; SF-88: Report of Medical Examination; SF-93: Report of Medical History; and CG-4920: Patient's Statement Regarding the Findings of the Medical Board need not be prepared, provided all other pertinent information (see chapter 3) is provided to the CPEB for its consideration. This documentation (which may be included in, or immediately following, the notification report) may be expedited by the use of telefax, E-Mail, overnight mail or message. To preclude error or misunderstanding, the CPEB will not act until it is satisfied that the available documentation provides sufficient information to consider the case and make the findings and recommended disposition.

e. The gathering of information is critical to a timely review of the findings following the CPEB's action and exercise of options. The command requesting an expedited review (see paragraph 4.A.10.b.) shall appoint a Coast Guard officer to proceed to the scene where the member and/or dependents are located to act as on-scene coordinator for the PDES legal counsel assigned to the evaluee. Where an officer is not reasonably available, a chief petty officer (E-7 or above) shall be assigned to act as the on-scene coordinator. In all cases, the person assigned as on-scene coordinator shall have access to the up-to-date information regarding the evaluee's SGLI information, possible SBP election, Record of Emergency Data and other personal information. Arrangements for provision of an on-scene coordinator for expedited review cases shall be formalized in appropriate unit Standard Operating Procedures (SOP).

f. The expedited review process should proceed as follows:

(1) Initial Action. A command requesting expedited review shall notify the Flag Plot Duty Officer who shall, in turn, contact the CPEB President. The CPEB President shall ensure that all written documentation necessary for the CPEB to make findings and recommended disposition has been received or is forthcoming.

(2) Assignment of Legal Counsel. At the earliest possible time, legal counsel will be assigned in accordance with paragraph 4.A.13.a.

4.A.10.f. (3) Initial Action By Legal Counsel. Legal counsel shall review the evaluee's personnel data record, the identity and location of the next of kin, and the legally appointed guardian or primary beneficiaries, as applicable.

(4) Action By CPEB.

(a) At the earliest possible time after all necessary documentation has been received, the CPEB shall assemble to consider the case. The required steps in the disability separation procedures as outlined in this chapter will be followed. All reasonable efforts shall be made to expedite the proceedings through the use of telefax, message, telephonic and verbal reports.

(b) After deliberation, the CPEB President shall notify the evaluee's legal counsel of the CPEB's findings and recommended disposition. If the CPEB recommends retirement, the evaluee shall be temporarily retired, if the offer is accepted.

(5) Action By Legal Counsel After CPEB. After receiving notice of the findings and recommended disposition of the CPEB, legal counsel shall:

(a) ensure that the evaluee, legal guardian, or next of kin, if available, is properly advised of the ramifications of accepting a retirement offer (particularly if hospitalized in a civilian facility);

(b) if applicable, ensure that the evaluee's Survivor Benefit Plan elections, Record of Emergency Data designations, and SGLI amount and beneficiaries are current; and

(c) if applicable, ensure that a DVA insurance election form, Application for Service-Disabled Veterans Life Insurance (RH), VA Form 29-4364, is executed after completion of CPEB action which culminates in retirement.

(6) Action On CPEB Findings and Recommended Disposition.

(a) The evaluee may accept or reject the CPEB findings and recommended disposition. If the evaluee is incapacitated, or when legal counsel reasonably believes on the basis of

4.A.10.f.(6) (a) (cont'd) competent medical or psychiatric evidence that the evaluee is incompetent to make such election, legal counsel shall make the election on the evaluee's behalf without need for convening the competency board prescribed by paragraph 4.A.11. If the evaluee has a court appointed legal guardian who is reasonably available, the legal guardian shall make the election on the evaluee's behalf. In any case where legal counsel accepts or rejects on behalf of the evaluee, legal counsel shall attempt to determine the evaluee's desires and make an election consistent with those desires.

(b) Legal counsel shall communicate orally the acceptance or rejection to the CPEB President as soon as a decision on the matter has been made, and confirm, in writing, both the election made and the party by whom it was made.

(7) Final Action. After the CPEB findings and recommended disposition are reviewed and approved, Commander (CGPC-opm) or (CGPC-epm), Coast Guard Personnel Command, as appropriate, will be advised to direct the temporary retirement.

11. Mental Competency. Except in expedited review cases, when reasonable doubt exists or arises during the course of consideration as to the mental competency of the evaluee, and this matter was not covered in the report of the medical board or other medical documentation accompanying the medical board record, a CPEB shall act as follows:

a. suspend its proceedings;

b. request that a mental competency board be convened in accordance with paragraph 3.C.3.; and

c. only resume consideration of the case upon receipt of the additional findings by the mental competency board relative to the competency of the evaluee. The findings of the mental competency board shall be made a part of the record.

12. Occasions for Suspension of CPEB Proceedings. CPEB proceedings may be suspended under the following circumstances:

a. If the evaluee's mental competence is in doubt.

4.A.12. b. If, between the time a medical board report has been submitted to the CPEB and the time of final action on the case,

(1) the evaluee's condition changes markedly; or

(2) the evaluee incurs additional impairments which may be disabling under paragraph 2.C.2.; the evaluee's commanding officer shall immediately notify Commander (CGPC-adm), Coast Guard Personnel Command by message.

c. If the information received is inadequate.

13. Policy Concerning Legal Counsel for the Evaluee.

a. Appointment of Legal Counsel for the Evaluee. Legal counsel for the evaluee will be assigned by Commandant (G-L).

b. Counseling Procedures. Upon designation and receipt of a copy of the CPEB findings and recommended disposition, legal counsel shall normally contact the evaluee within 5 working days. Legal counsel shall advise the evaluee of the disability process and of the evaluee's rights in light of the CPEB's findings and recommended disposition. Upon completion of counseling, the designated legal counsel will forward the CPEB Findings and Recommended Disposition, CG-4809, to the evaluee for signature and subsequent return.

c. Action in a Case of Incompetent Evaluee or a Case Where Disclosure of Findings Would be Deleterious to the Evaluee's Health. An evaluee in one of these categories imposes upon field personnel certain special constraints before action can be taken on CPEB findings and recommended disposition. The most critical situation is an evaluee who is incapacitated to an extent precluding his or her own consideration of findings and recommended disposition, e.g., the case in which the evaluee may not be conscious or lucid, or the case of an evaluee who has been declared legally incompetent by a court having jurisdiction. Other situations are cases in which disclosure of the board's findings and recommended disposition (or other material in the record) would be deleterious to an evaluee's health, or in which the evaluee has been found mentally incompetent by the CPEB. Upon receipt of CPEB findings and recommended disposition, the following pertains.

4.A.13. c. (1) Expedited Review Cases. Legal counsel must be prepared to act on CPEB findings and recommended disposition on behalf of an incapacitated or incompetent evaluee. Action on CPEB findings and recommended disposition in an expedited review case shall not be delayed pending the arrival of the next-of-kin or legal guardian.

(2) Non-Emergency Cases.

(a) Mentally Incompetent Evaluee. In the case where an evaluee has been found mentally incompetent, legal counsel shall, in the absence of a court-appointed legal guardian, act on behalf of the evaluee. In this case, legal counsel shall sign the form CG-4809 on behalf of the evaluee.

(b) Deleterious to Evaluee's Health Case. In the case where the CPEB has found that disclosure of the recommended medical findings (i.e., identification and narrative description of the disability) would be deleterious to the evaluee's health, even though that evaluee has not been determined to be mentally incom-petent, legal counsel is not authorized to accept or reject on behalf of the evaluee. In such a case, the evaluee will sign the acceptance or rejection of form CG-4809. Accordingly, legal counsel should photocopy the reverse side only of form CG-4809 for presentation to and signature by the evaluee. If, however, an evaluee is unwilling to accept or reject the findings and recommended disposition, the legal counsel shall enter a rejection on the evaluee's behalf.

14. Policy Concerning Action Following CPEB Findings and Recommended Disposition.

a. Commander (CGPC-adm), Coast Guard Personnel Command will notify the evaluee's command of the date on which the CPEB considered the evaluee's case. Command action shall be as follows:

(1) The evaluee must be readily accessible by telephone to designated legal counsel. Should the evaluee's location be other than that indicated in the medical board record, the command shall immediately notify Commander (CGPC-adm-1), Coast Guard Personnel Command with the evaluee's updated information.

4.A.14.a. (2) When an evaluee is contacted by legal counsel, the command shall make every effort to provide the evaluee with an appropriate environment. Ideally, this location should be a quiet room or private office to permit the evaluee to weigh the counseling being offered in the absence of excessive background noise or distractions.

(3) The time limits imposed on an evaluee for action on CPEB findings and recommended disposition require expeditious consideration of a major career decision. While the burden of meeting the time requirements rests with the evaluee, the command shall make every effort to assist the evaluee in so doing.

b. When an evaluee is found FIT FOR DUTY or Unfit for Continued Duty by Reason of Condition or Defect Not a Physical Disability, the evaluee may not accept or reject, but may submit a written rebuttal to within 15 working days of notification by legal counsel, with a copy forwarded directly to Commander (CGPC-adm-1), Coast Guard Personnel Command. The CPEB will review the rebuttal and reconsider the case if the evaluee's rebuttal raises issues that might change the original findings and recommended disposition.

c. After being counseled on the CPEB's Unfit For Contin-ued Duty findings and recommended disposition, it is the evaluee's responsibility to take one of the following actions to continue PDES processing:

(1) request reconsideration and submit, if available, information not previously presented to the CPEB;

(2) accept the findings;

(3) conditionally accept, pending approval of a retention request (see paragraph 4.A.15. for procedures);

(4) reject and demand a formal hearing at the FPEB; or

(5) simply waive continued disability processing and request administrative separation/retirement processing;

d. Should the evaluee fail to take one of the actions in paragraph 4.A.14.c. within 15 working days from the date of written notification of the CPEB's offer by legal counsel, the conclusive presumption is that

4.A.14. d. (cont'd) the evaluee is accepting the CPEB findings and recommended disposition, and the case will be forwarded to Commandant (G-L) for legal review.

15. Policy Concerning CPEB Findings and Recommended Disposition of Unfit For Continued Duty and Retention on Active Duty. In order to improve the efficiency of the PDES, the following procedures are implemented.

a. An evaluee who is found Unfit For Continued Duty by the CPEB and who has requested retention on active duty in accordance with the Personnel Manual, COMDTINST M1000.6 (series), chapter 17, will be permitted to make an acceptance of the CPEB findings and recommended disposition conditional upon approval of the retention request.

b. Upon receipt of the conditional acceptance from the evaluee, the CPEB coordinator will forward the case, with the CPEB findings and recommended disposition, conditional acceptance, and retention request directly to Commander (CGPC-epm) or (CGPC-opm), Coast Guard Personnel Command, as appropriate, for a decision on the retention request.

c. If the retention request is approved, the evaluee will be notified, and the case forwarded through the normal review chain for signature by the Final Approving Authority.

d. If the retention request is denied, a new CGHQ-4809 will be prepared. The evaluee will be notified, and paragraph 4.A.14.c. again applies, but the evaluee will not have the right to conditionally accept again.

B. Policy Governing Action Following Evaluee's Action on CPEB Findings and Recommended Disposition.

1. Action by Commanding Officer. Establish interim duty status as described in paragraph 3.L. Upon a command's request, home-awaiting-orders status may be authorized by Commander (CGPC-opm) or (CGPC-epm), Coast Guard Personnel Command, as appropriate.

2. Action by Evaluee's Legal Counsel.

a. After counseling the evaluee, the legal counsel will send the original of the CG-4809 to the evaluee. The evaluee will complete and sign the CG-4809 and return it to legal counsel along with, if applicable, the

4.B.2. a. (cont'd) letter requesting retention submitted in accordance with the Personnel Manual, COMDTINST M1000.6 (series), chapter 17 to Commander (CGPC-opm) or (CGPC-epm), Coast Guard Personnel Command.

b. If the evaluee rejects the CPEB findings and recommended disposition, Commander (CGPC-adm), Coast Guard Personnel Command shall notify the commanding officer that an FPEB is required and will provide appropriate details.

C. Final Action Following an Evaluee's Acceptance. The case will be forwarded to Commandant (G-LGL) for review for legal sufficiency. If legally insufficient, the record will be returned to the CPEB President with recommended corrective action. If legally sufficient, the record will be transmitted to the Final Approving Authority, who may take one of the following actions:

1. approve and forward the record to Commander (CGPC-opm) or (CGPC-epm), Coast Guard Personnel Command for implementation;

2. disapprove and refer the record back to CPEB for reconsideration, stating the reasons therefor; or

3. disapprove and forward to Commander (CGPC-adm-1), Coast Guard Personnel Command for hearing by an FPEB.

CHAPTER 5

FORMAL PHYSICAL EVALUATION BOARD (FPEB)

CONTENTS

CHAPTER 5. FORMAL PHYSICAL EVALUATION BOARD (FPEB)

A. Policy Governing the FPEB.

1. Description and Purpose. A FPEB is a fact-finding body which holds an administrative hearing to evaluate a member's fitness for duty and to make recommendations consistent with the findings. This hearing is not an adversarial proceeding, and the implication of litigation must be avoided.

2. Convening Authority. Commander (CGPC-c), Coast Guard Personnel Command assigns members to serve on the FPEB by precept, which lists all permanent and alternate members. Commandant (G-CCS) will assign members to serve on a FPEB by precept when the evaluee is a flag officer. The designation of members to serve on individual boards will be made by Commander (CGPC-adm), Coast Guard Personnel Command.

3. Authority. The FPEB evaluates the fitness for duty of all evaluees who have exercised their right to demand a full and fair hearing in accordance with 10 U.S.C. 1214. The FPEB also makes final recommendations concerning certain members on the TDRL in accordance with chapter 8 of this manual, and in cases referred pursuant to paragraph 4.A.6.

4. Membership of the FPEB. The FPEB normally consists of three commissioned officers, two of whom are normally line officers (or one line officer and one warrant officer) and the third a medical officer. In addition, there shall be assigned a counsel for the evaluee and a nonvoting recorder. A member of the CPEB may not serve as a member of the FPEB convened to hear the same case.

   a. A commissioned officer on active duty in the Coast Guard or Coast Guard Reserve, serving in pay grade O-6 or above shall be designated by the FPEB precept as permanent President. The precept may also designate alternate Presidents who are commissioned officers on active duty in the Coast Guard or Coast Guard Reserve, normally serving in pay grade O-5 or above, who shall act as President whenever designated by the Commander (CGPC-adm), Coast Guard Personnel Command. The designated President shall be senior to the evaluee when practicable.

   b. When a flag officer is the evaluee, a flag officer senior to the evaluee, if practicable, shall be designated as President of the FPEB.

5.A.4. c. The medical member will be a member of the United States Public Health Service. A medical officer who has served as a member of the Initial/Disposition Medical Board or CPEB shall not serve as a member of the FPEB convened to hear the same case.

d. When evaluating a member of the Coast Guard Reserve, one of the members of the board shall be a Coast Guard Reserve officer. See 10 U.S.C. 12643.

e. If the Board lacks a minority or female member, a minority or female evaluee may request the convening authority add or substitute a minority or female member, if reasonably available. A senior petty officer of at least pay grade E-7 may be substituted for the junior officer member upon request of an enlisted member. If practicable, the enlisted member so assigned shall be senior to the evaluee and in a rating in the specialty or related specialty of the evaluee.

f. When necessary to meet all membership requirements, there may be four or more voting board members.

g. Legal counsel for the evaluee shall be a commissioned officer on active duty in the Coast Guard or Coast Guard Reserve, designated by the Commandant (G-L), or counsel selected by the evaluee. If the evaluee elects to be represented by a disability counselor supplied by one of the veterans service organizations, e.g., Disabled American Veterans (DAV), or other counsel, such representation shall be at the personal expense of the evaluee or the organization providing counsel.

(1) Normally, legal counsel for the evaluee is assigned in accordance with paragraph 4.A.13.a.

(2) When the evaluee selects counsel other than Coast Guard legal counsel, he or she will not be provided a Coast Guard co-counsel, and the previously assigned Coast Guard legal counsel will, after conferring with the selected counsel and delivering relevant papers and documents, be discharged, at counsel’s request, from further participation in the case by the President of the FPEB.

h. If an evaluee fails to appear at the time specified before an FPEB convened to hear the case, the evaluee’s legal counsel, or selected counsel if available, shall represent the evaluee before the board. When the FPEB members decide that a personal appearance before a FPEB or disclosure of information relative to the physical or mental condition would adversely affect the evaluee’s health, the assigned legal counsel or selected counsel shall represent the

5.A.4. h. (cont'd) evaluee before the board, and the evaluee shall not be present during the proceedings, except to testify. (see paragraph 5.A.6.a.(1))

5. Duties of the Members.

a. Duties of All Members.

(1) It is the duty of each voting member to weigh the evidence impartially and to make recommended findings in conformity with applicable laws, regulations, and established policies. Whenever the issue is raised, voting members must decide whether the appearance of the evaluee before the board or disclosure to the evaluee of information concerning his or her physical or mental condition would adversely affect the evaluee's health. Each voting member has an equal voice with other members in deliberating upon and deciding each question cases freely in closed sessions. The opinions expressed by members in closed sessions shall not be disclosed to anyone.

(2) Voting members, legal counsel, and the recorder may question witnesses in an order prescribed by the president of the board.

(3) No board member may testify or be called as an expert witness.

b. Duties of the President. The president of the board is responsible for accomplishing various administrative aspects of a case and for presiding over the hearing as chief hearing office

(1) ensuring Commander (CGPC-adm), Coast Guard Personnel Command sets the time and place for the hearing, and ensuring appropriate notification to all persons involved;

(2) ensuring that a Statement of Rights of Evaluee, CG-3513, is prepared and forwarded to the evaluee as an enclosure to the notification of the hearing date. The evaluee shall be instructed to promptly complete and return such form, stating his or her elections, so that necessary action may be taken in accordance with his or her request. If the evaluee previously executed Form CG-3513, a copy need not be furnished;

(3) ensuring that the composition of the board meets the criteria set forth in paragraph 5.A.4.

5.A.5.b. (4) meeting with the recorder and legal counsel before the hearing to review the evidence of record, identify any witnesses to be called, and identify any anticipated stipulations, depositions or telephone testimony;

(5) resolving any conflicts encountered in accomplishing the functions required in paragraph 5.A.5.b.(3);

(6) presiding over the hearing as chief administrative hearing officer, administering the oath to the recorder, and for preserving order, decorum, and a courteous environment;

(7) adjourning or recessing the board, whichever best serves the proper transaction of the business before it, including conference of board members in closed session at any time; and

(8) ruling on such procedural matters pertaining to the hearing as may be raised.

c. Duties of the Recorder. The recorder is responsible for carrying out the following duties:

(1) adhering to the ethical standards of conduct for counsel before any formal fact finding body;

(2) prior to the board, ensuring members are familiar with their duties as described in this manual;

(3) presenting to the board all relevant available evidence. Evidence may include, but is not limited to: medical records; investigation re-ports; depositions; affidavits; statements; telephonic conference calls; and video and tape recordings. All evidence should be introduced directly or by way of incorporation by reference into the record. Unless made a part of the board record, such evidence, even though it may be found elsewhere in Coast Guard files, cannot be used. Evidence includes information relating to:

(a) the nature and extent of the evaluee’s impairment;

(b) the extent of impairment that existed at the time of entrance into active service, should it appear that the impairment existed prior to that date;

5.A.5.c.(3) (c) the line of duty status of the evaluee which bears on the circumstances in which the impairment was incurred;

(d) other circumstances relating to the evaluee's impairment; and

(e) any other issues to be decided;

(4) administering the oath to the president and other members of the board, legal counsel, and all witnesses;

(5) examining and cross-examining witnesses appearing before the board; and

(6) preparing a complete and accurate record of the proceedings of the board.

d. Duties of Legal or Selected Counsel. Along with representing, generally, the interests of the evaluee, the legal counsel shall coordinate with the recorder for the availability of witnesses, including telephonic witnesses. The president will rule on the need for witnesses to personally appear before the board. The board will rule on whether evidence is material, relevant or cumulative.

6. Rights and Appearance of the Evaluee.

a. Rights of Evaluee. The FPEB shall afford the evaluee a full and fair hearing, including:

(1) The right to a hearing before a board and to be in attendance, unless the members of the FPEB, after consulting with the evaluee's legal counsel, determine it is in his or her best interest not to be present;

(2) Not less than 3 working days notice of the time and place of the hearing, reasonable access to the record and any other evidence which the board is provided prior to the hearing;

(3) The right to legal or selected counsel;

(4) The right to present documentary evidence, including photographs, video tapes, X-rays, wit-nesses, and oral testimony, on one's behalf;

(5) Where evidence is presented which calls into question the reliability of the medical reports, the right to cross-examine the authors of reports who are present or can be readily contacted by telephone.

5.A.6. b. Order for Appearance. Except as provided in paragraph 5.A.5.a.(1), each evaluee is required to appear before the FPEB. If the evaluee requests to be excused, stating reasons in writing, Commander (CGPC-adm), Coast Guard Personnel Command may waive his or her appearance. Both the written request and a copy of the reply shall be attached to the record of the proceedings.

c. Failure to Appear.

(1) An evaluee who fails to appear before an FPEB convened to hear the case waives the right to be present at the hearing. The hearing may proceed, but the duty of legal or selected counsel to represent the evaluee as though the evaluee were present continues. (see paragraph 2.D.2.e., Administrative Investigations Manual (AIM), COMDTINST M5830.1 (series))

(2) An evaluee who fails to appear after receiving orders which specify the time and place to appear may be subject to disciplinary action.

B. Procedure Prior to Formal Hearing.

1. Action by Commander (CGPC-adm), Coast Guard Personnel Command. Commander (CGPC-adm), Coast Guard Personnel Command will act as follows:

a. Order the evaluee to appear before the FPEB.

b. Designate the time and place of hearing. The board need not meet from day-to-day but may recess for reasonable periods, as necessary, without requesting permission of the convening authority.

c. Publish a schedule of FPEB hearings, listing the convening date and board membership.

2. Preparation of Case by Evaluee and Legal Counsel.

a. The evaluee and legal counsel for the evaluee will be notified of the date of the convening of a formal board for preparation of the case. Legal counsel for the evaluee may examine all records and papers pertaining to the case, under such supervision as may be necessary to properly protect the records.

b. Should the legal counsel recognize a need for a delay in the presentation, a written request will be submitted to Commander (CGPC-adm), Coast Guard Personnel Command, whose response, as well as the request, will be appended to the record.

5.B.3. Preparation of Case by Members of the Board. The medical board record, official health record, personal data record (PDR) and any other papers having any bearing on the evaluee's physical or mental condition, except for CPEB proceedings, will be provided to the board members in advance of the hearing, and it shall be their duty to review such records prior to the hearing.

C. Procedure During Formal Hearing.

1. Evidence.

a. The board shall consider documentary evidence transmitted to it by proper authority, and such other evidence as may be adduced at the hearing. The board may also require and examine such records, other than CPEB proceedings, as may be in Coast Guard files that relate to the issues before the board

b. All oral evidence shall be taken under oath or affirmation and recorded.

c. The board may take notice of any generally accepted medical fact or principle. In consideration of the weight to be accorded evidence, the members of the board are expected to use their background, experience, common sense, and knowledge of human nature and behavior.

d. When the testimony presented at the hearing reveals that the evaluee claims to have impairments not disclosed by the medical records or presents credible evidence in conflict with the medical records and the issue thus drawn is not one that can be readily resolved by the observation of the board, the case should be continued and further developed by additional physical examination, special studies, or investigation by appropriate agencies.

e. Findings and recommended disposition of the board can only be based upon evidence of record.

2. Precept Read. When the board is called to order and after details of procedure have been decided, the precept convening the board and the appointment of the board members shall be read, unless waived by consent of the evaluee.

3. Oaths. All participants in the FPEB shall be sworn or affirmed. Once a participant has been sworn, repeat of the oath is not required for subsequent participation. The board recorder shall inform each witness, immediately after the witness has been sworn, of the subject matter before the board.

5.C.4. Medical Testimony.

a. A medical witness, if called, shall be questioned solely regarding the physical impairment(s) of the evaluee and how they affect bodily functions. Testimony should be based upon the medical board record, other medical records, and the medical witness's personal examination of the evaluee. Any conflict between a medical witness's testimony and other medical evidence shall be clarified. The medical evidence of record shall be clear and complete to permit the board to accurately and fairly evaluate and rate each impairment under the current VASRD.

b. In appropriate cases, upon determination by the board or at the request of the evaluee, legal counsel or the recorder, the testimony of a medical witness may be obtained by sworn statement or deposition. A request for such statement or deposition shall be forwarded by the President of the FPEB, to the medical witness or witnesses, setting forth specific questions, including any requests for clarification and amplification made by the evaluee, legal counsel, recorder, or the board. When testimony of a medical witness is to be obtained by deposition in lieu of a sworn statement, such testimony may be a written or oral deposition.

5. Testimony by the Evaluee. The evaluee may testify on any matter pertinent to his or her condition. However, the evaluee is not required to make any statement relating to the origin, incurrence, or aggravation of any disease or injury. (10 U.S.C. 1219)

6. Testimony by Other Witnesses. The recorder on behalf of the board, or the evaluee, may call other witnesses if those witnesses are reasonably available. If a witness is called, no part of the expense shall be borne by the Government with the exception of toll charges when testimony is by telephone.

7. Additional Statement by Witness. The board shall inform each witness immediately after being examined of the right to make any further statement on the record if the subject has not been fully brought out by the previous questioning. If the witness makes a statement, the board, the recorder, and the evaluee have the right to further examine the witness.

8. Telephone Testimony. The board may take sworn testimony by telephone conference call with the participation of the evaluee, legal counsel, voting board members, and the recorder.

5.C.9. Statements. Opening statements will be confined to the theory of the case. A discussion of controversial issues is inappropriate. After all evidence has been introduced, the recorder and legal counsel are afforded the opportunity to make any argument based upon the evidence of record.

10. Continuance. A continuance may, for good and sufficient reason, be granted by the President of the board upon motion of a member of the board, the evaluee, legal counsel, or the recorder.

11. Required Findings and Recommended Disposition of the FPEB.

a. When an active duty member appears before the FPEB, the FPEB's required findings and recommended disposition are to be in accordance with paragraphs 2.C.3.a. and 2.C.3.b.

b. When a member on the TDRL appears before the FPEB, the FPEB's required findings and recommended disposition are to be in accordance with paragraph 2.C.3.c.

c. When an inactive duty Reserve member appears before the FPEB, the FPEB's required findings and recommended disposition are to be in accordance with paragraph 2.C.3.b.

12. Minority Report. The FPEB's findings and recommended disposition shall be signed by the members concurring therein. Any member who does not concur may submit a minority report. The report shall be in memorandum format, addressed to the Final Approving Authority, via the Board President (or via the senior military member if the President is submitting the minority report). The President shall ensure that the members concurring in the majority report are afforded the opportunity to respond to the minority report if they so desire.

D. Procedure After Hearing.

1. Evaluee Furnished a Record of Board Findings and Recommended Disposition. Upon completion of board proceedings in the case, the recorder will provide the evaluee, or legal counsel when disclosure of the findings would be deleterious to the health of the evaluee, a letter setting forth the board's findings and recommended disposition. Receipt of this letter shall be acknowledged.

2. Rebuttal.

a. The President of the FPEB shall advise the evaluee and legal counsel that the board findings are not the

5.D.2. a. (cont'd) final determination of the Coast Guard and that the evaluee has the right to file a rebuttal to the FPEB findings and recommended disposition. The evaluee must decide whether or not to file a rebuttal within 3 working days from the date of the final adjournment of the board, and notify the FPEB in writing of the decision. If the evaluee does not notify the FPEB in writing of the decision within the 3 working day period, the evaluee's right to file a rebuttal is forfeited.

b. The rebuttal must be submitted within 15 working days of the final adjournment of the board. A postmark or dated receipt by a mailing or shipping entity shall establish "submission." Facsimile may be used to file a rebuttal by an evaluee having access to a facsimile terminal. The evaluee must state in the rebuttal the reasons for rebutting the decision of the FPEB, state the nature of his or her objection(s), and provide or cite evidence to support his or her position. A rebuttal may include substantial existing evidence, which by due diligence, could not have been presented before disposition of the case by the FPEB. A rebuttal that does not satisfy these requirements will not be acted upon, and the FPEB President shall so inform the evaluee.

c. If a letter of rebuttal is received within the required time frame, the FPEB will respond to the evaluee, or legal counsel (normally within 15 working days) confirming that the rebuttal has been received and considered.

(1) If, after consideration of the rebuttal, the FPEB is of the opinion that the elements contained in the rebuttal do not provide grounds for amendment of any portion of the FPEB's decision, the FPEB's response to the evaluee will state that the rebuttal does not support a change to the findings and recommended disposition. The evaluee and legal counsel will be informed that the entire record, including the rebuttal and the FPEB's response will be forwarded for further review and processing.

(2) If the FPEB concurs in all or in part of the evaluee's rebuttal, a new Proceedings and Recom-mended Findings of Coast Guard Physical Evalua-tion Board, CG-3511A, shall be prepared and forwarded to the evaluee, with a copy to legal counsel, reflecting the revised determination(s). The record shall then be forwarded for review and final action.

5.D.2. d. When the evaluee declines in writing to file a rebuttal, the record will be forwarded for review immediately. If a rebuttal is not submitted within 15 working days from the date of final adjournment of the FPEB hearing and the evaluee has not signed a declination of rebuttal, the record shall be forwarded and treated as if he or she declined to file a rebuttal.

3. Request for Retention on Active Duty. A request for retention on active duty, if applicable, shall be submitted in accordance with article 6-B-4 or chapter 17, Personnel Manual, COMDTINST M1000.6 (series).

4. Submission of the Records.

a. Assemble the record of proceedings of the FPEB in the following top to bottom order:

(1) Copy of letter requesting retention, if submitted.

(2) Record of Proceedings of a Coast Guard Physical Evaluation Board, CG-3510.

(3) Physical Evaluation Board Check List, CG-3512.

(4) Copy of board findings letter to evaluee, along with evaluee's receipt and statement, if any, concerning rebuttal. A certified mail receipt may serve in cases were the letter was sent by mail.

(5) Rebuttal, if any (original only).

(6) Copy of FPEB's letter response to the rebuttal, if any.

(7) Statement of Rights of Evaluee, CG-3513 (original only).

(8) Recorded verbatim transcript, as required. (see paragraph 5.D.5.)

(9) Proceedings and Recommended Findings of Coast Guard Physical Evaluation Board, CG-3511, with testimony attached.

(10) Proceedings and Recommended Findings of Coast Guard Physical Evaluation Board, CG-3511A.

(11) Explanatory statement, if any.

5.D.4. b. Forward the record of proceedings promptly to Commandant (G-L) for review for legal sufficiency, unless transmittal to the PRC is in order. (see paragraph 6.B.1.)

5. Transcripts. All FPEB hearings will be recorded verbatim on magnetic tape and retained for 5 years. Unless the permanent president of the FPEB determines that a verbatim written transcript is required, an audio tape of the FPEB proceedings will be provided to the evaluee:

a. when the evaluee or legal counsel has indicated that a rebuttal will be filed. The case will not be forwarded for review without a recorded verbatim transcript if the evaluee has indicated within the required 3 working days that a rebuttal is forthcoming, and the rebuttal is submitted within the required 15 working days. Copies of the recorded verbatim transcript will be provided to the evaluee and legal counsel;

b. when the case involves a determination of misconduct or not incurred in the line of duty;

c. when the findings and recommended disposition of the FPEB are not unanimous and the evaluee has indicated that a rebuttal will be filed. If the evaluee has accepted the board's findings and recommended disposition, the transcript may be reproduced either in part or in its entirety upon request of the board members, the PRC, or the Final Approving Authority in their respective reviews of the minority report; or

d. when subsequent PRC action results in substitute findings which are appealed to the Physical Disability Appeal Board (PDAB).

6. Disciplinary Action. If an evaluee becomes subject to disciplinary action after appearing before the FPEB, the evaluee's commanding officer shall notify Commander (CGPC-adm), Coast Guard Personnel Command by message stating the action taken or contemplated. Further action in the case will be governed by Article 12-B-1.e., Personnel Manual, COMDTINST M1000.6 (series). Subsequent developments in the case shall be promptly reported. (see also paragraph 2.C.11.)

7. Change in Evaluee's Status or Physical Condition Before Final Action. Whenever there is any significant change in the evaluee's status or physical condition before final action is taken, the evaluee's commanding officer shall promptly notify Commander (CGPC-adm), Coast Guard Personnel Command. Subsequent developments in the case shall reported as well.

CHAPTER 6

PHYSICAL REVIEW COUNSEL (PRC)

CONTENTS

CHAPTER 6. PHYSICAL REVIEW COUNCIL (PRC)

A. Policy Governing the PRC.

1. Description and Purpose. The PRC is a review body.

2. Convening Authority. Commander (CGPC-c), Coast Guard Personnel Command convenes the PRC by precept, which lists all permanent and alternate members. Assignment of council members will be made by Commander (CGPC-adm), Coast Guard Personnel Command.

3. Membership of the PRC.

   a. In a case other than one in which a transcript is required by paragraphs 5.D.5.b. and c., PRC membership shall normally consist of one commissioned officer on active duty in the Coast Guard or Coast Guard Reserve, serving in pay grade O-5 or above, who is designated by the PRC precept as president. The precept may designate other members who are commissioned officers on active duty in the Coast Guard or Coast Guard Reserve, serving in pay grade O-3 or above, who shall act for the president whenever directed.

   b. For a case listed in paragraphs 5.D.5.b. and c., or when specifically directed by the PRC president, the PRC membership shall consist of two additional mem-bers, who have not previously served as a member of the CPEB or FPEB that evaluated the evaluee.

      (1) The military member will be a commissioned officer on active duty in the Coast Guard or Coast Guard Reserve, serving in pay grade O-3 or above.

      (2) The medical member will normally be a member of the U.S. Public Health Service assigned to the Coast Guard.

B. Functions of the PRC.

1. The PRC shall review every CPEB or FPEB case in which the evaluee rebuts the findings and recommended disposition. In conducting this review, the PRC will check for completeness and accuracy, and ensure consistency and equitable application of policy and regulation.

2. The findings and recommended disposition of an FPEB will not normally be modified on review unless they were clearly erroneous. Due regard shall be given to the opportunity of the board members to observe the evaluee and judge the credibility of witnesses.

6.B.3. In its review, the PRC shall not substitute its judgment for that of the CPEB or FPEB. The PRC must concur with the findings and recommended disposition of the CPEB or FPEB unless one or more of the following clearly identified errors or omissions is noted in the record.

a. Incorrect assignment of VASRD code(s);

b. Pyramiding of impairments;

c. Incorrect percentage of disability assigned to the VASRD descriptive diagnosis/code(s); or

d. Insufficient evidence to support the findings and recommended disposition, i.e., the CPEB's or FPEB's decision was arbitrary, capricious, not in compliance with law or regulation, or an abuse of discretion.

4. If the PRC identifies one of the errors described above, he or she shall take one of the following actions:

a. return the case to the CPEB or FPEB president for reconsideration or remedial action, as appropriate;

b. if a CPEB case, refer the case to the FPEB for consideration; or

c. if an FPEB case, refer the case to a three member PRC for consideration and disposition. Only a three member council can make substitute findings and recommendations.

5. The evaluee shall not appear before the PRC. However, the evaluee or counsel may submit to the PRC in writing, new or heretofore unconsidered evidence, or any otherwise pertinent information, with appropriate comment.

6. The PRC shall recommend to the Commander (CGPC-c), Coast Guard Personnel Command that a member's name be removed from the TDRL at the 5-year expiration date without benefits when the member, by failing to report for a physical examination, renders impracticable a final determination of fitness to perform the duties of grade/rating, or the degree of disability.

C. Actions of the PRC.

1. Action when No Error is Identified. After reviewing a case, the PRC shall, in the absence of error, concur with the findings and recommended disposition of the CPEB or FPEB.

6.C.2. When Substitute Findings and Recommended Disposition Are Made.

a. Whenever the PRC substitutes findings and recommended disposition, it shall cite specific elements in the record to support its action(s), and/or cite grounds for identifying the findings or recommended disposi-tion in which it finds error or omissions and, as appropriate, provide recommended corrections. The evaluee will be given an opportunity to file a rebuttal and/or to appeal modified findings and recommended disposition by the PRC if one or more of the following findings and/or recommended dispositions is made:

(1) Not fit for duty, instead of the rebutted FPEB finding of fit for duty;

(2) Fit for duty, instead of the rebutted FPEB finding of not fit for duty;

(3) Separation, instead of the rebutted FPEB recommended disposition of permanent retirement or placement on the TDRL;

(4) Permanent retirement, instead of the rebutted FPEB recommended disposition of placement on the TDRL;

(5) A change to "not in line of duty", "not the proximate result of the performance of active duty", or "not entitled to basic pay";

(6) Decreased combined percentages of disability; or,

(7) Change in a finding that the injury or disease resulted from a disability caused by an instrumentality of war, occurred in line of duty during a period of war, or was incurred in combat with an enemy of the United States, to a disability not so caused.

b. The evaluee shall be furnished a copy of the substitute findings and recommended disposition together with a summary of the PRC's reasons for the modification(s). If the PRC makes the substitute findings and recommended disposition listed in paragraph 6.C.2.a., the evaluee shall execute the first endorsement to the PRC letter (see exhibit 6-1) and forward the endorsement to Commander (CGPC-adm-1), Coast Guard Personnel Command to arrive within 15 working days from the date he or she receives the substitute findings and recommended disposition from the Coast Guard Personnel Command. If the evaluee

6.C.2. b. (cont'd) concurs with the substitute findings and disposition, the case will be forwarded to Commandant (G-LGL) for legal review, and to the Commander, Coast Guard Personnel Command, final approving authority. The rebuttal shall specify the findings and recommended disposition not concurred with, and set forth the basis for disagreement.

c. If a rebuttal is not received within the prescribed period and the evaluee has not signed a declination of rebuttal, the evaluee will be deemed to have concurred with the findings and recommended disposition of the PRC.

d. If a rebuttal is submitted by the evaluee or counsel, the PRC shall give due consideration to the arguments in the rebuttal. The PRC shall either:

(1) adhere to the initial substitute findings and recommended disposition, whereupon the evaluee shall be so notified and advised of the right to request a hearing before the PDAB; or

(2) modify the substitute findings and recommended disposition. If the modification is in agreement with the rebuttal, the case will be forwarded to Commandant (G-L) for review for legal sufficiency. If the modification is not in agreement with the rebuttal, the evaluee shall be advised of the right to request a hearing before the PDAB.

3. Minority Report. Findings and recommended disposition shall be signed by those concurring. Any member not concurring with the findings and recommended disposition of the majority shall submit a minority report to be appended to the record.

1850
Date_____

FIRST ENDORSEMENT on President, Physical Review Council ltr 1850
of _____, Case No. _____

From:
To: Commander (CGPC-adm), Coast Guard Personnel Command

Subj: PHYSICAL EVALUATION BOARD

____ 1. I have reviewed the substitute findings and recommended disposition of the Physical Review Council and I CONCUR with such findings and recommended disposition.

IF YOU CHECKED NUMBER 1 ABOVE, NO FURTHER ACTION IS NECESSARY OTHER THAN YOUR SIGNATURE.

____ 2. I have reviewed the substitute findings and recommended disposition of the Physical Review Council and I DO NOT CONCUR with same. My written rebuttal is attached hereto for further consideration by the Physical Review Council. If the members of Physical Review Council still fail to resolve the matter favorably in my behalf, I understand that my case will be submitted to the Physical Disability Appeal Board for consideration. I have checked the appropriate block(s) below expressing my desires in this connection:

a. **IF YOU CHECKED NUMBER 2 ABOVE, ONE OF THE FOLLOWING MUST BE CHECKED:**

____ I request appearance before the Physical Disability Appeal Board at my own expense.

____ I will not appear before the Physical Disability Appeal Board.

b. **IN ADDITION, IF YOU CHECKED NUMBER 2 ABOVE, ONE OF THE FOLLOWING MUST ALSO BE CHECKED:**

____ I request previously assigned legal counsel continue to represent me in this matter.

____ I will furnish civilian counsel of my choice at my own expense.

____ I will be represented by other counsel.

_____
(Signature)

Exhibit 6-1

CHAPTER 7

PHYSICAL DISABILITY APPEAL BOARD (PDAB)

CONTENTS

CHAPTER 7. PHYSICAL DISABILITY APPEAL BOARD (PDAB)

A. Policy Governing the PDAB.

1. Description and Purpose. A PDAB's role is to review the complete records of those disability evaluation cases referred to it. This review shall be consistent with accepted medical principles and applicable laws, regulations, and directives.

2. Convening Authority. Commander (CGPC-c), Coast Guard Personnel Command establishes the PDAB by precept, which lists all permanent and alternate members. Commandant (G-CCS) will establish a separate PDAB by precept to review cases of flag officers. Commander (CGPC-adm) assigns the members to serve on individual boards.

3. Functions. The PDAB shall consider cases referred to it in accordance with chapter 6. In considering a disability evaluation case referred to it, the PDAB shall deter-mine whether:

   a. The member received a full and fair hearing;

   b. The evaluation proceedings conformed to applicable laws, regulations, and published directives and policies, and followed accepted medical principles; and,

   c. The findings and recommended disposition of the FPEB, as modified by the PRC, are supported by a preponderance of the evidence.

4. Membership of the PDAB. The PDAB shall consist of at least three commissioned officers: a president, a medical member and a military member. In addition, there shall be assigned a counsel for the evaluee and a non-voting recorder.

   a. The president shall be a commissioned officer on active duty in the Coast Guard or Coast Guard Reserve, serving in pay grade O-6 or above. When the case of a flag officer is being considered by the PDAB, the president will be a flag officer. When practical, the president shall be senior to the evaluee.

   b. The military member shall be a Coast Guard officer and, if practical, senior to the evaluee.

   c. The medical member shall normally be a medical officer (physician) of the Public Health Service assigned to the Coast Guard.

7.A.4. d. When evaluating a member of the Coast Guard Reserve, one member of the board shall be a Coast Guard Reserve officer senior to the evaluee as required by 10 U.S.C. 12643. Failure to meet this requirement will negate the proceedings.

e. Upon request of the evaluee, the convening authority may include a minority, female, or enlisted board member, if reasonably available. A senior petty officer of at least pay grade E-7 may be substituted for the junior officer member upon request of an enlisted member. The enlisted member so assigned shall be senior to the evaluee when evaluating an enlisted person, if practical, and in a rating in the specialty or related specialty of the evaluee.

f. When necessary to meet all membership requirements, there may be four or more voting board members.

g. Any one who served as a member of the IMB, DMB, CPEB, FPEB, or PRC upon which the referral to the PDAB is based, or had been a witness at an FPEB, may not serve as a member of the PDAB with regard to that case.

h. Legal counsel for the evaluee shall be a commissioned officer on active duty in the Coast Guard or Coast Guard Reserve, designated by Commandant (G-L), or a civilian attorney employed by the evaluee. The evaluee, however, may elect to be represented by a disability counselor supplied by one of the veterans service organizations, e.g., Disabled American Veterans (DAV). (see paragraph 7.A.4.i.)

i. Normally, legal counsel for the evaluee is assigned in accordance with paragraph 4.A.13. of this manual. When the evaluee has selected other legal counsel, he or she will normally not have a Coast Guard co-counsel, and the previously assigned Coast Guard legal counsel will, after an opportunity has been provided to confer with civilian counsel and deliver relevant papers and documents, be discharged from further obligations in the case.

j. If an evaluee fails to appear at the time specified before a PDAB convened to hear the case, the evaluee’s counsel shall represent the evaluee before the board. When the PDAB members decide that personal appearance before a PDAB or disclosure of information relative to the physical or mental condition would adversely affect the evaluee’s health, the assigned counsel shall represent the evaluee before the board, and the evaluee shall not be present during the proceedings.

B. Procedures. The PDAB will meet in open session for presentation of the case and at the conclusion thereof shall meet in closed session for its deliberations and determinations. The evaluee may appear in person before the PDAB during open sessions of the board except that no expense for either the evaluee's or civilian counsel's appearance will be borne by the U.S. Government. An evaluee who, after due notification of the time and place of hearing, fails to appear at the appointed time, is deemed to have waived the right to appear. An evaluee may also expressly waive the right of appearance by notifying Commander (CGPC-adm), Coast Guard Personnel Command in writing. (see exhibit 6-1)

1. Oaths. All participants in the PDAB shall be sworn or affirmed. Once a participant has been sworn, repeat of the oath is not required for subsequent appearances before the PDAB evaluating the same evaluee. The board recorder shall inform each witness, immediately after the witness has been sworn, of the subject matter before the board.

2. Challenges. A member of the PDAB may be challenged for cause. If a challenge for cause is raised, the convened board will recess and consider the challenge. The challenged member will not participate in the consideration or the decision. When the board reconvenes, the president will announce the board's decision as to whether the case will continue or adjourn to obtain a new member.

3. Evidence.

   a. Not less than 10 working days prior to the date set for the hearing, a copy of the available records and papers to be considered by the PDAB shall be furnished to the evaluee's counsel, board members, and the recorder.

   b. Not less than 3 working days prior to the date set for the hearing, the evaluee or counsel and the PDAB recorder may submit a brief to the president of the PDAB with copies to all board members, the recorder, evaluee and/or counsel (as appropriate) regarding the issues in the case, the names of any witnesses and any new or additional evidence that is considered relevant.

   c. The PDAB shall consider the entire record transmitted to it by proper authority. The board may examine any other Coast Guard records which relate to the issues at hand. Any evidence having probative value as to the determination of issues before the board may be presented. The board shall assure that the evaluee or counsel is aware of the evidence it is considering.

7.B.3. d. The presence of witnesses is neither required nor encouraged. The counsel for the evaluee and the recorder are encouraged to use telephonic depositions and stipulations and other expeditious means to bring relevant evidence before the board. However, the board may call military personnel and physicians under Coast Guard jurisdiction as witnesses whose presence is requested by the recorder, the evaluee, or the evaluee's counsel, only when the witnesses are reasonably available and only if, in the opinion of the president of the board, there is no other reasonable way to obtain the evidence they would present. It is the responsibility of the evaluee and counsel to make arrangements for the attendance of a civilian witness who is to appear on behalf of the evaluee. No cost incurred in obtaining civilian witnesses will be borne by the U.S. Government.

e. All witnesses before the board shall be subject to questioning by the evaluee, counsel, recorder for the board, and the board members. All oral testimony shall be taken under oath or affirmation administered by the recorder. All PDAB hearings will be recorded on magnetic tape which shall be retained for five years. Unless the permanent president of the FPEB determines that a verbatim transcript is required, an audio tape of the PDAB procedings will be provided:

(1) When the case involves a determination of misconduct or not-in-line of duty; or

(2) When the decision of the PDAB is not unanimous;

4. Continuances. The PDAB may continue a hearing on its own motion or at the request of the evaluee, counsel, or recorder.

C. Actions. The PDAB will take one of the following actions and forward the case to Commandant (G-L) for review for legal sufficiency:

1. Concur with the FPEB;

2. Concur with the PRC; or

3. Return the record to the appropriate board for reconsideration of any matter deemed pertinent.

D. Minority Report. Any member of the PDAB may submit a minority report on any issue on which he or she disagrees. This report shall be included in the record of proceedings of the board.

7.E. Proceedings of the Board. The President of the PDAB shall take appropriate action to ensure that all sessions of the board are conducted with proper decorum but in a relaxed, courteous, and orderly manner. Interlocutory questions will be ruled on by the President. Objections to these rulings may be made by any other member of the board. These objections shall be decided by a majority vote of the board members in closed session. The President shall announce the board's decision and the result of any vote upon interlocutory questions.

F. Forwarding of Record of Proceedings. The record of proceedings of the PDAB shall be authenticated by the President or in the President's absence, the next senior member of the board. Once authenticated, it shall then be forwarded to Commandant (G-L) for review for legal sufficiency. Upon completion of legal review, the record will be forwarded to the Final Approving Authority.

CHAPTER 8

TEMPORARY DISABILITY RETIRED LIST (TDRL)

CONTENTS

CHAPTER 8. TEMPORARY DISABILITY RETIRED LIST (TDRL)

A. Overview.

1. A member who is qualified for disability retirement under 10 U.S.C. 1201 or 10 U.S.C. 1204 will be placed on the TDRL in accordance with 10 U.S.C. 1202 or 10 U.S.C. 1205 when the disability is not permanent.

2. Placement on the TDRL does not guarantee a member permanent disability retirement. The TDRL is likened to a "pending list". It provides a safeguard for the Government against permanently retiring members who may later fully, or partially, recover from the disabling condition. Conversely, the TDRL safeguards members from being permanently retired with a condition that is not stable and could result in a higher disability rating.

3. Requirements for placement on the TDRL are the same as for permanent disability retirement, except that the disability is not stable. The disability must render the member unfit to perform the duties of his or her office, grade and rank or rating, and the disability must be rated at a minimum of 30 percent or higher, unless the member has 20 years of active service for retirement purposes.

4. Temporary retirement status implies no inherent right for retention on the TDRL for the entire 5 year period pro-vided by 10 U.S.C. 1210. Upon review of a periodic physical examination and a determination that the member's condition is of a permanent nature and stable, a CPEB or FPEB may recommend removal of the member's name from the TDRL by separation with severance pay, permanent disability retirement, or a finding of "Fit for Duty", as appropriate.

5. Upon review of a periodic physical examination and a subsequent determination that the member's condition is not stable and that the member continues to be unfit for duty, a CPEB or FPEB may continue the member's name on the TDRL. Such cases will be continued with the same determination that was approved when the member's name was originally placed on the TDRL. The continuation shall become a part of the total case record.

6. If a member's name is not sooner removed from the TDRL, his or her disability retired pay terminates at the end of 5 years.

8.B. Assignment to the TDRL. When an evaluee's temporary retire-ment is finally approved, Commander (CGPC-adm), Coast Guard Personnel Command shall place the member's name on the TDRL and shall be responsible for managing the case until final determination is made.

C. Periodic Physical Examination and CPEB Review. A member on the TDRL must undergo periodic physical examinations and CPEB review to determine if the member's condition has stabilized sufficiently to adjudicate the case. An examination and review is required:

1. at least once every 18 month period;

2. not less than 12 months prior to the termination of 5 years from the date the member was first placed on the TDRL; or

3. at any other time as specified by appropriate authority.

D. Preparing a TDRL Case for CPEB Review.

1. Orders to Member for Periodic Physical Examination. Commander (CGPC-adm), Coast Guard Personnel Command will determine the schedule and initiate orders directing a member on the TDRL to undergo a required physical examination. The orders shall inform the member:

   a. that a physical examination is required during a prescribed month;

   b. that a specified medical treatment facility will schedule the examination and will advise the member when and where to report; and

   c. of authorized travel information.

2. Request to Medical Treatment Facility. Concurrent with the issuance of orders to the member, Commander (CGPC-adm), Coast Guard Personnel Command will forward a copy of the case to the medical treatment facility, requesting an examination be scheduled. The medical treatment facility will make the appropriate appointments and advise the member when and where to report for examination.

3. Completion of Physical Examination. The examining physician will develop a Narrative Summary (as described in chapter 3) that presents an objective and complete evaluation of the member's current condition. The medical treatment facility will return the copy of the case with the Narrative Summary to Commander (CGPC-adm), Coast Guard Personnel Command for CPEB action.

E. CPEB Periodic Review. The CPEB shall evaluate each case and recommend removal of the member's name from the TDRL if the member's condition is of a permanent nature and stable. In this regard, the CPEB shall adhere to the policies prescribed in paragraph 2.C.3.c.

1. If the CPEB retains a member on the TDRL, Commander (CGPC-adm), Coast Guard Personnel Command will notify the member, in writing, of the board's decision.

2. In all other instances, including the final periodic review, the member's name must be removed from the TDRL. The CPEB shall consider the case in accordance with the provisions of paragraph 2.C.3. Commander (CGPC-adm), Coast Guard Personnel Command shall then process the case for final determination as outlined in chapter 4.

F. TDRL Members Residing in Foreign Countries. TDRL members who reside in foreign countries are responsible to report for their periodic physical examinations when ordered. Travel within the United States from and to debarkation and embarkation points and the medical treatment facility will be authorized and reimbursed. Upon request, Commander (CGPC-adm), Coast Guard Personnel Command may attempt to arrange for a uniformed services medical treatment facility in the area where the member is located to conduct a periodic physical examination. However, if such arrangements are not made, the member is still obligated to comply as ordered. If the member fails to report for the periodic examination, Command-er (CGPC-adm), Coast Guard Personnel Command may initiate action to stop disability retired pay in accordance with 10 U.S.C. 1210(a).

G. Periodic Physical Examination Not Performed.

1. Failure To Report. If a member fails to report or fails or refuses to complete a physical examination, Commander (CGPC-adm), Coast Guard Personnel Command shall make an effort to discover the reason. If the reason for the member's failure to report cannot be discovered or is found unjustified, and the TDRL expiration date has not been reached, Commander (CGPC-adm), Coast Guard Personnel Command may initiate action to stop the member's disability retirement pay. Unless removed sooner by other action, the member's name shall remain on the TDRL until the 5 year expiration date, at which time the evaluee's name shall be removed from the TDRL in accordance with paragraph 6.B.6.

2. Unable To Locate Member. When reasonable efforts to locate the member are unsuccessful, Commander (CGPC-adm), Coast Guard Personnel Command shall send a certified letter, return receipt requested, to the member at the last known address. This letter will state the

8.G.2. (cont'd) obligation to comply with orders and advise the member to contact Commander (CGPC-adm), Coast Guard Personnel Command within a fixed period of time. If this effort is unsuccessful, Commander (CGPC-adm), Coast Guard Personnel Command will take the action prescribed in paragraph 8.G.1.

3. Restoring Disability Retirement Pay. The member's disability retirement pay may be reinstated and, if warranted, may be retroactive for a period not in excess of 1 year if, in the opinion of the Final Approving Authority, failure to respond was justified.

H. Removal Upon TDRL Expiration Date. 10 U.S.C. 1210(b) requires a final determination of the case of a member whose name is on the TDRL upon expiration of 5 years after the date when the member's name was placed on that list. When a case cannot be considered due to the member's failure to undergo a final physical examination, the case shall be forwarded to the PRC. (see paragraph 6.B.6.)

CHAPTER 9

APPLICATION OF THE DEPARTMENT OF VETERANS AFFAIRS SCHEDULE FOR RATING DISABILITIES (VASRD)

CONTENTS

B—Rating Principles (cont'd)

CHAPTER 9. APPLICATION OF THE DEPARTMENT OF VETERANS AFFAIRS SCHEDULE FOR RATING DISABILITIES (VASRD)

A. General Rating Policies.

1. Use of the Department of Veterans Affairs (DVA) Schedule for Rating Disabilities.

a. Congress established the Department of Veterans Affairs Schedule for Rating Disabilities (VASRD), published in 38 CFR, Part 4, as the standard under which percentage determinations are to be made pursuant to Title IV of the Career Compensation Act of 1949 (now principally codified in Chapter 61 of Title 10, U.S.C.). However, not all of the general policy provisions set forth in Subpart A (4.1 through 4.31) of 38 CFR, Part 4, are applicable to the Coast Guard. Many of these policies were written primarily for DVA rating boards, and are intended to provide guidance under laws and policies applicable only to the DVA.

b. Section A of this chapter replaces Subpart A of the VASRD, 38 CFR, Part 4, with the exception of Table I which is referenced in paragraph 9.A.12. The remain-der of the VASRD (4.40 et seq.) is applicable to the Coast Guard except those portions that:

(1) Pertain to DVA determinations of service connection;

(2) Refer to internal DVA procedures or practices; or

(3) Are otherwise specifically identified in section B of this chapter as being inapplicable.

c. The following policy applies to an evaluee whose initial entry into the PDES occurs subsequent to 9 July 1987:

(1) There is no legal requirement, in making disability retirement determinations, to rate a physical condition, not in itself considered to be disqualifying for military service, along with another condition that is determined to be dis-qualifying, in arriving at the rated degree of incapacity incident to retirement from military service for disability. Except as discussed in (2) below, in making this professional judgment board members will not rate those disabilities neither unfitting for military service nor contributing to the inability to perform military duty.

9.A.1.c. (2) In applying this policy, board members should take into consideration the residuals of the original impairment that has now led to the member being found unfit for continued duty. An example of this would be a member with a brain tumor, who after surgery to remove the tumor, is left with partial paralysis and an artificial plate replacing the surgically removed portion of skull. In this instance, it would be proper to rate both the paralysis and the missing portion of skull. Another example is the member who, as the result of an accident, has a splenectomy as well as an amputated major arm. Even though the loss of the arm is the disability, it would be proper to rate the splenectomy as it is an immediate result of the original accident.

2. Essentials of Evaluative Rating.

a. The VASRD is used in the evaluation of disability resulting from all types of diseases and injuries encountered as a result of or incident to military service. The percentage ratings represent, as far as can practicably be determined, the average impairment in earning capacity resulting from such diseases and injuries, and their residual conditions, in civilian occupations.

b. Conditions which do not render the member unfit for continued service will not be considered for determining the compensable disability rating unless they contribute to the finding of unfitness.

3. Higher of Two Evaluations.

a. It is not expected that every case will show the exact symptomatology specified in the VASRD, especially with the more fully described grades. Findings which are sufficiently characteristic of the symptoms described in the VASRD and the evaluee's disability are adequate. Above all, coordination of rating with impairment of function is required in all instances. There is no rigid requirement for the presence of all enumerated manifestations of a given disability. Those manifestations which are sufficiently and significantly representative of the entity and the severity of limitations imposed on the member are the only requirements.

b. Where there is a reasonable doubt as to which of two percentage evaluations should be applied, the higher evaluation will be assigned if the disability picture more nearly approximates the criteria for that

9.A.3. b. (cont'd) rating. Otherwise, the lower rating will be assigned. When, after careful consideration of all reasonably procurable and assembled data, there remains a reasonable doubt as to which rating should be applied, such doubt shall be resolved in favor of the member, and the higher rating assigned.

4. Pyramiding.

a. Pyramiding is the term used to describe the application of more than one VASRD rating to any area or system of the body when the total functional impairment of that area or system is more appropriately reflected under a single diagnostic code. Pyramiding is not permitted as it results in overrating the disability.

b. Disability from injuries to the muscles, nerves, and joints of an extremity may overlap to a great extent, and special rules for their evaluation are included in appropriate sections of the VASRD and in section 9.B. of this chapter. Related diagnoses should be merged for rating purposes when the VASRD provides a single diagnostic code covering all their manifestations. This prevents pyramiding and reduces the chance of overrating. For example, disability from fracture of a tibia with malunion, limitation of dorsiflexion, eversion, inversion, and traumatic arthritis of the ankle would be evaluated 5262 in accordance with the effect upon ankle function with no separate evaluation for the limitation of motion or traumatic arthritis.

5. Total Disability Ratings. Total disability will be considered to exist when the evaluee's disability is sufficient to render it impossible for the average person to follow a substantially gainful occupation. Accordingly, in cases in which the VASRD does not provide a 100 percent rating under the appropriate (or analogous) diagnostic code, an evaluee may be assigned a disability rating of 100 percent if the disability is sufficient to render it impossible for an evaluee to follow a substantially gainful occupation. However, if the VASRD pro-vides a 100% rating, the evaluee must be rated in accordance with the specified criteria. Total disability may not be found in conjunction with temporary retirement unless the impairment can reasonably be expected to continue for the five year maximum TDRL period. Total disability may not be found in conjunction with permanent retirement unless the impairment can reasonably be expected to continue throughout the life of the evaluee.

6. Convalescent Ratings. Under certain diagnostic codes, the VASRD provides for convalescent ratings to be awarded for specified periods of time without regard to the

9.A.6. (cont'd) actual degree of impairment of function. Such ratings do not apply to the Coast Guard since the purpose of convalescent ratings is accomplished by other means under disability laws. Convalescence will ordinarily have been completed by the time maximum hospital benefit (for disposition purposes) has been attained. The ratings for observation periods as distinguished from convalescence, such as those "for one year" following treatment for a malignant neoplasm, are not affected by this policy.

7. Analogous Rating. When an unlisted condition is encountered, rate the disability under a closely related disease or injury in which not only the functions but the anatomical localization and symptomatology are closely analogous. Conjectural analogies will be avoided, as will the use of analogous ratings for conditions of doubtful diagnoses, or those not fully supported by clinical and laboratory findings. Ratings assigned to organic diseases and injuries will not be assigned by analogy to conditions of functional origin. The diagnostic code number will be "built up" by taking the first two digits from that part of the VASRD most closely identifying the system of the body involved. The last two digits will be "99," which will denote an unlisted condition, followed by a slant bar and the diagnostic code number that is most closely related to the actual impairment. For example, Aortic Valvular Heart Disease rated by analogy to Rheumatic Heart Disease 7099/7000.

8. Zero Percent Ratings and Minimum Ratings.

   a. Occasionally a medical condition which causes or contributes to unfitness for military service is of such mild degree that it does not meet the criteria even for the lowest rating provided in the VASRD under the applicable diagnostic code. A zero percent rating may be applied in such cases even though the lowest rating listed is 10 percent or more, except when "Minimum Ratings" are specified (see paragraph 9.A.8.b.). It should be noted that the zero percent rating is a valid disability rating and receives the same compensation as prescribed by law for ratings of less than 30 percent. It does not mean that a disability does not exist. The bilateral factor will be applied when a disability is present in two paired extremities, even though one is rated at zero per-cent.

   b. In some instances the VASRD provides a "minimum rating," without qualification as to residuals or impairment. Syringomyelia, diagnostic code 8024, is an example. The diagnosis alone is sufficient to justify the minimum rating. Higher ratings may

9.A.8. b. (cont'd) be awarded in consonance with degree of severity, but no rating lower than the "minimum" may be used if the diagnosis is satisfactorily established.

c. The VASRD provides for minimum rating for "residuals" in certain conditions. The instructions may be "rate residuals, minimum _____," or may specify what impairment to rate and give a minimum rating for that impairment. Examples are 8011, anterior poliomyelitis, and 6015 benign new growth of eyeball and adnexa, other than superficial. To justify the minimum rating for residuals, a functional impairment or other residual must exist. Otherwise a zero percent is appropriate.

9. Extra Schedular Ratings in Exceptional Cases. In exceptional cases, where schedular evaluations are found to be inadequate to properly rate the disability, extra schedular ratings commensurate with the average earning capacity impairment due exclusively to the service connected disability may be assigned. Full documentation is essential in the case record and in the findings of the board, clearly demonstrating the basis of the conclusion that the case presents such an exceptional or unusual disability picture as to render impracticable the application of the regular schedular standards. Such related factors as marked interference with employment, frequent periods of hospitalization, or extreme physical problems associated with the treatment and its side effects will justify the assignment of extra schedular ratings.

10. Rating Disabilities Aggravated by Active Service. It is necessary in all cases of this type to deduct from the present degree of disability the degree, if ascertain-able, of the disability existing prior to entry (EPTE) into active service. The difference between the current disability and the EPTE portion is considered to be the result of aggravation by active service. However, if the disability is total (100 percent), the portion existing prior to entry will be recorded, but no deduction in the compensable rating will be made. Determination of EPTE disability can be made whether or not the disability was noted upon entry if the evidence of record is sufficient to establish its preexistence (see paragraph 2.C.5.). If the degree of disability at the time of entry into the service is not ascertainable in terms of the VASRD schedule, the EPTE factor will be rated as zero percent, and the current disability will be considered totally the result of aggravation. If the percentage of disability at the time of entry on active service is the same as the current disability, the percentage attributable to aggravation is "NONE," not zero percent.

11. Assignment of Aggravation Factors When Prescribed Treatment is Refused or Omitted. An evaluee's degree of disability may have been aggravated or increased by an unreasonable failure or refusal to submit to medical or surgical treatment or therapy, to take prescribed medications, or to observe prescribed restrictions on diet, activities, or the use of alcohol, drugs, or tobacco. The compensable disability rating may be reduced to compensate for such aggravation/increase when the existence and degree of aggravation are ascertainable by application of accepted medical principles, and where it is clearly demonstrated that:

    a. The evaluee was advised clearly and understandably of the medically proper course of treatment, therapy, medication, or restriction; and

    b. The evaluee's failure or refusal was willful or negligent, and not the result of mental disease or of physical inability to comply.

12. Combined Ratings Table. When an evaluee has more than one compensable disability, the percentages are combined rather than added (except when a "Note" in the VASRD indicates otherwise). This results from the consideration of the evaluee's efficiency as affected first by the most disabling conditions in the order of their severity. Thus, an evaluee having a 60 percent disability is considered to have a remaining efficiency of 40 percent. If an evaluee has a second disability rating at 20 percent, he or she is considered to have lost 20 percent of that remaining 40 percent, thus reducing the remaining efficiency to 32 percent. Hence, a 60 percent disability combined with a 20 percent disability results in a combined value of 68 percent, which is rounded up to a rating of 70 percent. The combined rating for any combination of disabilities can be determined by first arranging the disabilities in their exact order of severity and then referring to the combined ratings table, table I in 4.25 of the VASRD, in accordance with the following instructions:

    a. Combining Two Percentages. Enter the ratings table by locating the highest percentage in the left-hand column and reading across to where that horizontal line intersects with the vertical column headed by the next highest percentage.

        EXAMPLE: 40 combined with 20 equals 52

    b. Combining Three or More Percentages. First, combine the first two percentages as above. Second, reenter the table by locating that combined value in the left-hand column headed by the third percentage.

9.A.12. b. (cont'd)

EXAMPLE: 50 combined with 30 equals 65. 65 combined with 20 equals 72

If there are additional percentages, the second step is repeated using the new combined value and the next percentage.

c. Converting Combined Ratings. After all percentages have been combined, the resulting value is converted to the nearest number divisible by 10. Combined values ending in 5 will be adjusted upward. If the combined value included a decimal fraction of .5 or more as a result of applying the bilateral factor, the fraction is converted to the next higher whole number; otherwise the decimal fraction is disregarded.

EXAMPLE: If the combined value is 64.5, first round off the fraction to make the combined value 65, which in turn is rounded off to 70. If the combined value is 64.4, the decimal fraction is disregarded and the combined value of 64 is rounded off to 60

13. Bilateral Factor. When a partial disability results from injury or disease of both arms, or both legs, or of paired skeletal muscles, the rating for the disabilities of the right and left sides will be combined as usual, and 10 percent of this value will be added (not combined) before proceeding with further combinations, converting to degree of disability. The bilateral factor will be applied to such bilateral disabilities before other combinations are carried out, and the rating for such disabilities, including the bilateral factor as above, will be treated as a disability for the purpose of arranging in order of severity and for all further combinations.

a. The use of the terms "arms" and "legs" is not intended to distinguish between the arm, forearm, and hand, or the thigh, leg, and foot, but to describe the upper extremities and lower extremities as a whole. Thus with a compensable disability of the right thigh (for example, amputation of leg at thigh level), and one of the left foot (for example, pes planus), the bilateral factor applies, and similarly whenever there are compensable disabilities affecting use of paired extremities regardless of location or specified type of impairment (except as noted in 9.A.13.c.).

b. The correct procedure when applying the bilateral factor to disabilities affecting both upper extremities and both lower extremities is to combine the ratings of the disabilities affecting the four extremities in order of each's individual severity,

9.A.13. b. (cont'd) and apply the bilateral factor by adding, not combining, 10 percent of the combined value thus attained.

c. The bilateral factor is not applicable unless there is partial disability of compensable degree in the VASRD in each of two paired extremities or paired skeletal muscles. Special instructions regarding the applicability of the bilateral factor are provided in various parts of the VASRD, e.g., diagnostic code 7114 - 7117, diagnostic code 8205 - 8412, etc. The bilateral factor is not applicable in skin disabilities rated under diagnostic code 7806.

14. Use of VASRD Diagnostic Code Numbers.

a. The VASRD diagnostic code numbers appearing opposite the listed ratable disabilities are arbitrary numbers for the purpose of showing the basis of the evaluation assigned and for statistical analysis.

b. Great care will be exercised in selecting the applicable diagnostic code number and in its citation on the rating sheet. Each rated disability is assigned the VASRD diagnostic code number unless a hyphenated code is expressly authorized. It is not proper to use additional diagnostic codes as a means of further describing the defects. The written diagnosis entered on the rating form should include any description considered necessary to indicate the extent, severity, or etiology of the condition.

c. In selecting diagnostic code numbers, injuries will generally be represented by the number assigned to the residual condition on the basis of which the rating is determined.

d. With diseases, the rating level of the disability is usually determined by decreased functional capacity, taking into account the level of medication for the disease. Preference is to be given to the number assigned to the disease itself. If the rating is determined on the basis of residual conditions, the number appropriate to the residual condition will be added, preceded by a hyphen. Thus atrophic (rheumatoid) arthritis with the residual of ankylosis of the lumbar spine would be coded "5002-5289." In this way, the exact source of each rating can be easily identified. If there are several residuals, the major functional impairment should be the manifestation used to rate the individual, e.g., 7325-7301 (regional enteritis after a small bowel resection with obstruction due to adhesion).

9.A.14. e. In citing disabilities on rating sheets, any combination of diagnostic terminology from the medical board or VASRD which accurately reflects the degree of disability may be used. Residuals of diseases or therapeutic procedures will not be cited without reference to the basic disease. Hyphenated or slant bar diagnostic codes are used only in the following circumstances:

(1) When the VASRD provides that a listed condition is to be rated by residual, e.g., myocardial infarction rated as arteriosclerotic heart disease (7005-7006) or nephrolithiasis rated as hydronephrosis (7508-7509).

(2) When the VASRD provides a minimum rating and the disability is being rated on residuals, e.g., multiple sclerosis rated as incomplete paralysis of all radicular groups (8018-8513).

(3) When an unlisted disease, injury or residual condition is encountered, the diagnostic code number will be "built-up". The first two digits will be selected from the schedule of the involved body part and the last two digits will be "99." For example, spondylolithesis would be rated analogous to sacroiliac injury and weakness (5299/5294).

B. Rating Principles. Disabilities are listed in VASRD diagnostic code number sequence. Instructions and explanatory notes which follow are listed according to the diagnostic code number in the VASRD. Only those conditions which require special comment or those which have been the cause of misunderstanding in the past are included.

1. 5000, Osteomyelitis, Acute, Subacute, or Chronic.

a. Note (1) following diagnostic code 5000 in the VASRD may appear to be ambiguous in its instructions concerning applying the amputation rule. It means that in rating active osteomyelitis of any part, the amputation of which would be ratable at less than 30 percent (ordinarily the minimum) rating for active osteomyelitis, a rating of 10 percent may be assigned. This constitutes disregard of the amputation rule in those instances where the rating for amputation at that level is ratable at zero percent. Example: A case of active osteomyelitis of the little finger distal to the proximal interphalangeal joint may be rated at 10 percent even though amputation at that level is ratable at zero percent. However, a ratable disability exists only so long as the distal phalanx with its active osteomyelitis remains.

9.B.1. b. Osteomyelitis should not be considered cured simply because saucerization or sequestrectomy has been performed. Cures sometimes may be effected, however, by removal or radical resection of the bone.

c. Under note (2), a rating may be assigned only when the disease is active clinically, by x-ray, or other laboratory studies.

d. Osteomyelitis extending into a major peripheral joint will not be rated higher than the elective amputation level that would remove the involved joint.

2. 5002, Rheumatoid Arthritis. A distinction is made between active disease and chronic residuals. Diagnostic codes 5002, 5004 to 5009 and 5017 are ratable on the same criteria using the guidance provided under diagnostic code 5002.

a. As an active process: Ratings assigned under these diagnostic codes will be based primarily on clinical and laboratory evidence. X-ray changes are not required.

b. For chronic residuals: Ratings will be based on limitation of motion in accordance with the diagnostic code 5200 series. X-ray evidence, alone, will not support a rating in any of these conditions.

c. The bilateral factor will apply as appropriate.

d. The ratings under diagnostic code 5200 series will not be combined with ratings for active process.

3. 5003, Arthritis, Degenerative (Hypertrophic or Osteoarthritis).

a. This is one of the more frequently encountered conditions in the field of disability evaluation, and one of the more difficult to adjudicate. The difficulty stems from the fact that it occurs in some degree in all individuals beyond age 40, and from its wide variability in rate of progression and severity of manifestations. Symptomatology is frequently disproportionate to demonstrable pathology, and in this area the effect of such intangibles as motivation and other psychogenic components must be considered.

b. Ratings under this diagnostic code can be assigned in either of the following situations: In the absence of limitation of motion with only x-ray evidence of involvement of two or more major joints or two or more minor joint groups; or, when there is objective

9.B.3. b. (cont'd) evidence of some limitations of motion combined with x-ray findings of arthritis of one or more major joints or minor joint groups.

c. When the limitation of motion of the involved specific joint or joints is of sufficient degree, the rating assigned will be under one of the appropriate limitation of motion diagnostic codes (the 5200 or 9900 series of codes).

d. When a rating is assigned under a limitation of motion diagnostic code (5200 series), it will not be combined with a rating under diagnostic code 5003 for other joint involvement on the basis of x-ray findings.

e. It should be emphasized that separate ratings of specific joints or joint groups are not intended for application to the fluctuating types of impairments which tend to improve or disappear.

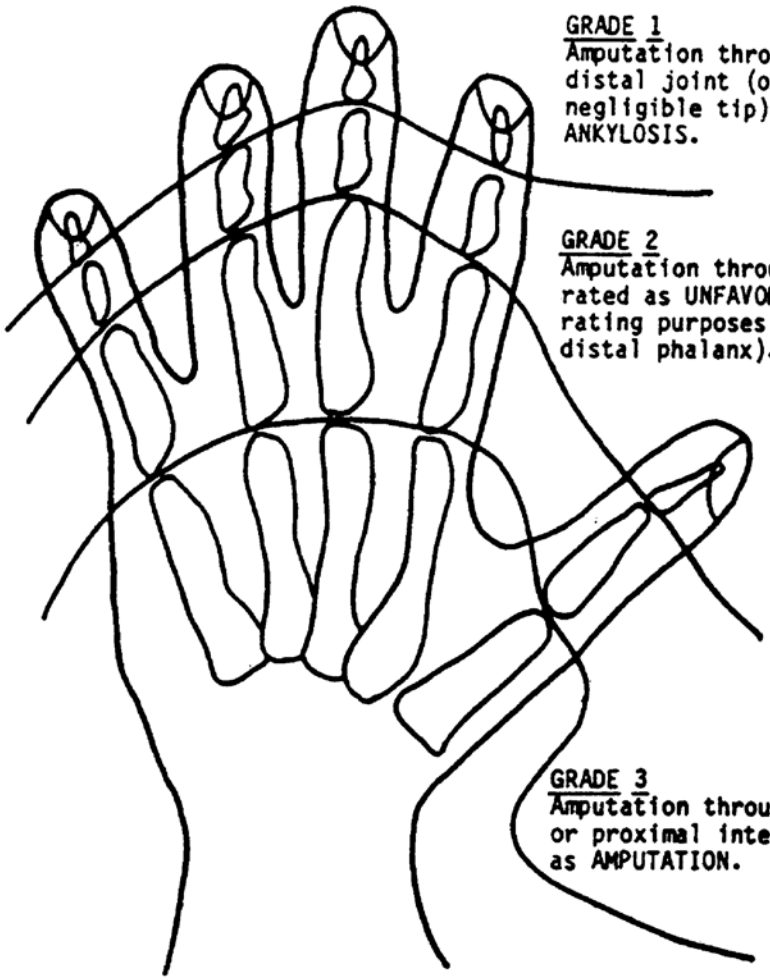
4. 5010, Arthritis, Due to Direct Trauma. When an affected joint merits a rating higher than 10 percent, the analogy appropriate to the impairment must be used. Diagnosis alone is insufficient for a 10 percent rating. With an affected joint, the assignment of a 10 percent rating requires the presence of objective evidence of limitations of motion in addition to x-ray findings.

5. 5054, Total Hip Replacement. Amputation rule applies at middle or lower third of thigh. In uncomplicated cases the member is usually ambulatory and disposition is possible approximately one month after the procedure has been performed. Place on TDRL, if appropriate, and rate for residuals after stabilization. Convalescent rating and ratings for a specified period of time do not apply.

6. 5055, Total Knee Replacement. Convalescent ratings will not be used. The minimum rating of 30 percent may be disregarded if full function is restored and the member may be found FFD. If, after maximum hospital benefit has been achieved, a member remains unfit, rate for residual impairment. TDRL, with an appropriate rating, is usually required prior to permanent disposition.

7. 5126-5151, Multiple Finger Disabilities. The difficulty frequently encountered in rating multiple finger disabilities has been simplified by a convenient method of computation. By assigning graded values for each finger according to the level at which it was amputated, or for the severity of its ankylosis, it is possible to calculate an "average amputation level" for the fingers involved. (See Figure 9-1) The disability may then be rated in accordance with the notes of instruction in the VASRD. The method is as follows:

RATING OF MULTIPLE FINGER DISABILITIES



GRADE 1
Amputation through the distal phalanx or distal joint (other than loss of negligible tip): rated as FAVORABLE ANKYLOSIS.

GRADE 2
Amputation through the middle phalanx rated as UNFAVORABLE ANKYLOSIS. (For rating purposes, the thumb has NO distal phalanx).

GRADE 3
Amputation through the proximal phalanx or proximal interphalangeal joint rated as AMPUTATION.

GRADE 4
Amputation of resection of metacarpal bones, more than one-half of the bone lost.

Figure 9-1

9.B.7. (cont'd)

a. Step One. Determine the grade value for each of the affected fingers from the chart in exhibit 9-1, below.

FINGER AMPUTATION GRADE LEVEL CHART

Defect of Individual Finger	Rated As	Grade Value
Amputation through distal phalanx or distal joint. (Other than negligible tip losses)	Favorable ankylosis (Note c, page 31-2R VASRD)	Grade 1
Amputation through middle phalanx	Unfavorable ankylosis (Note b)	Grade 2
Amputation through proximal phalanx or proximal I-P joint	Amputation (Note a)	Grade 3
Amputation of entire digit, with amputation or resection of more than one half of the metacarpal	Single finger amputation with metacarpal resection (codes 5152 through 5156)	Grade 4

Exhibit 9-1

[NOTE: For rating purposes the thumb will be regarded as having no distal phalanx. Amputation of the thumb at the interphalangeal joint or distal thereto will be graded as unfavorable ankylosis (Grade 2). The VASRD is ambiguous in this regard; no such distinction being made in the notes following diagnostic code 5151, yet diagnostic code 5152 shows 20 percent for application at the distal joint or distal thereto, and diagnostic code 5224 also shows 20 percent for application to unfavorable ankylosis of the thumb.]

b. Step Two. Find the average grade value by dividing the total of values for the individual fingers by the number of fingers involved. Round off fractions to the nearest whole number.

c. Step Three. From the second and third columns of the chart above, determine the appropriate category of the defects (favorable ankylosis, unfavorable ankylosis, amputation, etc.) for the average grade of the disabled hand. The proper diagnostic code number and rating can be determined within that category according to the number of fingers involved.

Example: An evaluee has amputated a thumb through the distal phalanx, the index and little finger through the middle phalanges, and the entire ring finger, including more than one-half of the metacarpal.

Grade value for the thumb ---------- 2
Grade value for the index finger ---------- 2
Grade value for the little finger ---------- 2
Grade value for the ring and metacarpal ---------- 4
Total value ----------10

$$\frac{\text{Total Value}}{\text{Number of fingers involved}} = \text{Ratable Value}$$

$$\frac{10}{4} = 2\ \tfrac{1}{2} = 3$$

Referring again to exhibit 9-1, Grade 3 is ratable as amputation. Amputation of four fingers—thumbs, index, ring and little—is ratable under diagnostic code 5130 at 70 percent (for major hand) or 60 percent (for minor hand). Unfavorable ankylosis of four fingers—thumb, index, ring and little—is ratable under diagnostic code 5217 at 60 percent (for major hand) or 50 percent (for minor hand).

8. 5171, Amputation of Great Toe. Must be through the proximal phalanx to warrant a 10 percent rating.

9. 5200-5295, Ratings Involving Joint Motion.

a. General.

(1) In the measurement and assessment of joint motion, it is incumbent upon the medical examiner to use the standardized description portrayed in Plates I and II (pages 4.71-2 and 4.71-3) of the VASRD.

(2) When the reported limited range of motion falls between two points specified in the VASRD, the higher percentage of disability will apply.

(3) Ankylosis is the absence of motion of a joint. In application it is complete fixation, or a limitation of motion so severe in degree that the amount of movement is negligible.

(4) The inclination (usually encountered when an analogous rating of an extremity is necessary) to use an analogy such as "other impairment of" elbow or knee (diagnostic code 5209 or 5257) is to be avoided when the actual impairment is a

9.B.9. a. (4) (cont'd) limitation of motion of the joint, which is properly ratable as limitation of flexion or extension of the part distal to the joint.

(5) In some cases of limitation or of other abnormal joint motion, the basic cause is injury to muscle or tendon rather than to bone or joint, and thus 5300 series is applicable.

b. 5205-5208, Absence or Limitation of Motion of Elbow and Forearm.

(1) 5205. Where a rating for unfavorable ankylosis is not based upon the additional finding of complete loss of supination or pronation, it may be combined with 5213 subject to the amputation rule. If there is less than complete loss of supination or pronation, 5205 may be combined with 5213 but not to exceed the rating for unfavorable ankylosis under 5205.

(2) 5206-5208. These will combine with 5213 but not to exceed the rate for unfavorable ankylosis under 5205.

c. 5209-5212, Other Impairments of Elbow, Radius, and Ulna. These diagnostic codes are not to be combined with diagnostic code 5213.

d. 5213, Impairment of Pronation and Supination.

(1) Limitation of either pronation or supination may be rated, but never both in the same area. Full pronation is the position of the hand flat on a table. Full supination is the position of the hand palm up. In rating limitation of pronation, the "arc" is from full supination to full pronation. The "middle" of the arc is the position of hand palm vertical to the table.

(2) There is an inconsistency in the VASRD for the ratings for the major arm: "hand fixed near the middle of the arc or moderate pronation" is rated 20 percent; however, limitation of pronation with "motion lost beyond middle of arc" is rated 30 percent. Cases in which this conflict arises shall be resolved in the member's favor.

(3) "Motion lost beyond last quarter of arc" means that the forearm can be pronated from 0° through 45° , but no further. (See 4.71 of the VASRD.)

9.B.9. e. 5214, Wrist, Ankylosis of. Ankylosis of the wrist in 10° to 30° of dorsiflexion will be considered favorable and rated accordingly. Rate wrist replacement prosthesis according to functional impairment.

f. 5251-5253, Limitation of Extension and Flexion of the Thigh. Ratings allowable under these diagnostic codes may not realistically reflect the degree of disability because of basic or related disability of the sacroiliac region, pelvis, acetabulum, or head of femur. More appropriate ratings may be selected from diagnostic code 5250 (hip, ankylosis of), diagnostic code 5255 (femur, impairment of) or diagnostic code 5294 (sacroiliac injury and weakness). (See 4.67 of the VASRD for comments on pelvic skeletal fractures.)

g. 5255-5262, Defects of Long Bones of the Lower Extremity. Apply these diagnostic codes (malunion, with adjacent joint disability) when appropriate to avoid multiple diagnostic codes and ratings. However, when both a proximal and distal major joint are affected, an additional rating may be indicated for the less disabled joint. These diagnostic codes are often appropriate when joint surfaces are included in the fracture lines.

h. 5270, Ankle ankylosis. Ankle prosthesis may be rated under this number. The maximum disability is 40 percent in keeping with the amputation rule. Place on TDRL if appropriate and rate on residual disability after stabilization.

i. 5272, Subastragalar or Tarsal Joint Ankylosis. The assignment of a rating under this diagnostic code is only proper in the absence of motion of the subtalar joint which is manifested by the lack of inversion or eversion of the foot.

j. 5285-5295, The Spine.

(1) The joints of the cervical, dorsal, and lumbar segments of the spine and the combination of sacroiliac and lumbosacral joints are each regarded as a group of minor joints. Each is ratable as one major joint only when separate ratings are justified by x-ray evidence of pathology in addition to limitation of motion or muscle spasm or other evidence of painful motion of the individual segments involved. Otherwise, rate as for osteoarthritis.

9.B.9.j. (2) Arthritic impingement on nerve roots which produces degeneration of the nerve function or frequent, prolonged attacks of neuralgia, as distinguished from brief episodes of radiating pain, should be rated as one entity under diagnostic codes for neurological conditions, unless limitation of spinal motion justifies an additional rating.

k. 5285, Residuals of Fracture of Vertebra.

(1) The need for a member to wear some type of brace for the restriction of lumbar or dorsolumbar movement is not analogous to the requirement for a jury mast type of neck brace for abnormal mobility following cervical fracture. Where there is no cord involvement, the disability should be rated in accordance with the degree of limited motion with the brace in place.

(2) When there is significant demonstrable (objective findings and x-ray) deformity (see paragraph (3) below) of one or more vertebral bodies, 10 percent is to be added to, not combined with, the rating for each spinal segment in which such deformity appears. Instructions contained in the italicized note under diagnostic code 5285 pertaining to ratings for ankylosis and limited motion apply also to the addition of 10 percent for demonstrable deformity of a vertebral body. The 10 percent is to be added to the rating for the segment before that rating is combined with the other ratings.

Example: If, as residuals of vertebral fractures, a member were to have moderate limitation of motion in cervical and lumbar segments, and substantial deformities of the bodies of C5, T12, and L1, the rating would be as follows:

Line 1.	Diagnostic code 5285-5290 --------	20
2.	Demonstrable deformity of C5 ----	+10
3.		30
4.	Diagnostic code 5285-5292 --------	20
5.	Demonstrable deformity of L1 ----	+10
6.		30
7.	Combining lines 3 and 6 ----------	51

Since there is no associated finding, there can be no addition because of deformity in T12.

(3) The addition of 10 percent, to the appropriate rating, for demonstrable deformity of a vertebral body is intended only for a substantial degree of

9.B.9. k. (3) (cont'd) deformity. It should not be added in those instances of insignificant deformity, e.g., slight shortening of the anterior vertical dimension of the body. Where a successful spinal fusion has been performed because of the deformity of a vertebral body, the potential of the deformity for increasing the degree of disability has usually been removed or so far reduced that the addition of 10 percent to the rating is not justified.

l. 5286, Ankylosis of Spine. Use this diagnostic code to rate ankylosing spondylitis (Marie-Strumpell's Disease). This disease frequently includes arthritic-like symptoms in peripheral joints, including the temporomandibular joint, in addition to the spine. Peripheral joints will not be rated separately. Once the clinical diagnosis has been established, a 60 percent "favorable angle" rating will be assigned. This will account for all possible manifestations of the disease during its progression. The recommended disposition will usually be permanent retirement (unless other separate disabilities warrant temporary retirement) because the member can never be expected to return to duty, and the natural progression of the disease is such that the disease will still be active at the end of the maximum 5-year TDRL period. Since the manifestations of the disease are such that the active phase of this disease lasts 10-12 years, and an ankylosed spine is generally the only residual impairment, the total disability ratings described in paragraph 9.A.5. do not apply.

m. 5287-5289, Ankylosis of a Spinal Segment.

(1) A rating for ankylosis requires a condition of absent or negligible range of motion for the whole segment. Ankylosis of part of a segment still may leave some degree of useful motion for the segment as a whole, so that the appropriate rating would be for limitation of motion.

(2) Separate ratings for ankylosis of segments of the spine shall not exceed 60 percent when combined if the combined effect of such separate disabilities is complete ankylosis of the spine at a favorable angle.

10. 5296, The Skull.

a. Diagnostic burr holes and other bony defects are ratable only when there is loss of both inner and outer tables of bone. Where there are more than one, the areas of each should be added, and the total

9.B.10. a. (cont'd) rated. The following chart (exhibit 9-2) may be helpful as a reference in determining appropriate ratings.

CONVERSION CHART

1 centimeter = 0.3937 inches
1 inch = 2.54 centimeters
1 square centimeter = 0.1550 square inch
2 square centimeters = 0.3100 square inch
3 square centimeters = 0.4650 square inch

Diameter of Circle	Square Centimeter	Square Inch
1 Centimeter	0.7854	0.1216
2 Centimeters	3.1416	0.4869
3 Centimeters	7.0686	1.0956
4 Centimeters	12.5664	1.9478
½ Inch*		0.19635
1 Inch		0.7854
1 ½ Inches		1.76715
2 Inches		3.1416

*Size of the average diagnostic burr hole

Exhibit 9-2

b. Considering total bone loss for multiple areas such as in trephining, the rating should not be assigned based upon "coin measurement" but on the basis of the aggregate area loss in terms of square inches. Attention is directed to the fact that approximately 50 percent of diagnostic burr holes heal within 5 years.

c. Loss of part of the skull is ratable whether or not the defect has been repaired with a prosthetic plate. Residual neurological deficit or cosmetic deformity will be rated separately if appropriate. Burr holes, to be ratable, must be contiguous.

d. Areas of loss where bone regeneration has taken place are not ratable. If regeneration has partially closed the defect, only the remaining area of loss is to be rated.

e. The rating problem created by the disparity in the criteria for area measurement (50 cent piece = 1.140 square inches; 25 cent piece = 0.716 square inch) shall be resolved in favor of the member.

9.B.11. 5297, Removal of Ribs.

a. The VASRD, for removal of ribs, requires the complete removal from the vertebral angle to the costo-cartilaginous junction. Removals to a lesser degree are rated as rib resections.

b. The presence of certain conditions precludes the assignment of an additional rating under diagnostic code 5297; however, exceptions are allowed in specific situations. Notes (1) and (2) under this diagnostic code in VASRD provide pertinent guidance.

12. 5299/5255, Hip Arthroplasty and Prostheses. The disability resulting from defects requiring hip prostheses shall be rated under diagnostic code 5054.

13. 5299/52xx, Dupuytren's Contracture. Rate on the basis of limitation of motion of finger(s).

14. 5301-5326, Muscle Injuries. When a joint is ankylosed, the muscles acting on that joint shall not be additionally rated.

15. 6000-6092, Diseases of the Eye.

a. General considerations.

(1) Rating of eye diseases should be based on central visual acuity, field of vision, and muscle function.

(2) The combined rating for disabilities of the same eye is not to exceed the amount for total loss of vision of that eye unless there is an enucleation or a serious cosmetic defect. When there is a cosmetic defect, even though limited to the eye with the visual loss, representing a separate and distinct entity, namely, facial disfigurement, a separate rating is permitted under diagnostic code 7800, to be combined with the rating for the visual loss or rating for enucleation.

(3) The Goldman Perimetry Test must be used to determine visual field, and diplopia. Do not follow instructions given in 4.76 of the VASRD.

b. 6000-6009, Conditions Involving Structures of the Globe. Disabilities resulting from these conditions shall be rated as follows:

(1) Step One.

(a) Rate impairment of visual acuity.

9.B.15. b. (1) (b) Rate impairment of field of vision.

(c) Rate active pathology, if present, at 10 percent.

(d) Combine the rating in (a) or (b) above, whichever is higher, with (c).

(2) Step Two. Rate pain, rest requirements and/or episodic incapacity from 10 to 100 percent. This rating, when only one eye is involved, is not necessarily limited to the 30 percent rating for total loss of vision of one eye, since pain or rest requirements may be incapacitating in any degree including total. Assign this rating under whichever one of the diagnostic codes covers the basic condition, i.e., diagnostic code 6000 through 6009. Analogy to another diagnostic code number is not required. It is an estimate based as nearly as possible upon the actual impairment of social and industrial function which is imposed by the pain experienced, the time lost because of the requirement for rest, the frequency of incapacitating episodes, or any combination thereof. Do not combine an additional rating of 10 percent during continuance of active pathology with this rating.

(3) Step Three. Award the higher of the two ratings resulting from steps one and two above.

(4) Step Four. Retained Foreign Body. Rate as active pathology under Step One, if in critical area or not stabilized, or rate for residuals under Step Two.

c. 6013, Glaucoma, Simple, Primary, Noncongestive. The minimum rating is applicable if the diagnosis is satisfactorily established, whether or not visual acuity or field of vision has been affected. The rating is for the disease rather than for functional impairment of an individual organ and applies whether the disease process involves one or both eyes.

d. 6029, Aphakia. The expression "one step less" used in the note under this diagnostic code in the VASRD refers to less vision, not to percentage evaluation.

e. 6080, Field vision, impairment of. The results of the Goldman Perimetry Test are utilized in determining the rating for concentric contraction of field of vision. If the resulting field of vision is proportionally decreased and in basically the same shape as the normal field of vision, the temporal degree reading is utilized in entering this diagnostic code for

9.B.15. e. (cont'd) the appropriate rating. If the resulting field of vision is skewed to a large extent, the member's impairment is normally rated more accurately under another diagnostic code that describes the underlying problem or visual acuity. If no diagnostic code accurately describes the cause of the skewing, an analogous rating to a diagnostic code that best describes the impairment in terms of "total person" will be utilized.

f. 6081, Scotoma, Pathological. The rating is 10 percent for the unilateral condition. It may be combined with other ratings, with the reservation that the rating for one eye may not exceed 30 percent unless there is an enucleation or a serious cosmetic defect. Central scotoma cannot, however, be combined with central visual loss.

16. 6090-6092, Diplopia. To determine rating, substitute the 6090 reading for the visual acuity of the poorer eye and read percentage in the 6070-6079 series. If vision is the same in both eyes, pick one as an arbitrary choice. For example, if a member has 20/50 vision bilaterally with central diplopia, rate as 5/200 one eye and 20/50 other eye under 6073 at 40 percent.

17. 6200-6260, Diseases of the Ear.

a. 6100-6110, Impairment of Auditory Acuity.

(1) The evaluations for deafness derived from the VASRD are intended to make proper allowance for improvement by hearing aid. Examination to determine this improvement is therefore unnecessary.

(2) Evaluation of this impairment will be through the use of either Table VI (Numeric Designation of Hearing Impairment) or, when necessary, Table VIa (Average Puretone Decible Loss), and Table VII (Percentage Evaluations for Hearing Impairment (with diagnostic codes) of the VASRD. Puretone averaging for purposes of the VASRD will be accomplished by adding the decibel losses at frequencies of 1000, 2000, 3000, and 4000 Hz and dividing the answer by 4.

(3) Most audiometric examinations now being performed use as reference-zero level that one recommended by The American Standards Institute (ANSI), which is essentially identical, for rating purposes, to the International Standards Organization (ISO) levels. The American Standards Association (ASA) reference standards are numerically less than, and may be converted to, the ISO and ANSI levels, by adding the difference in decibels at each

9.B.17. a. (3) (cont'd) frequency in the normal range of hearing, as follows:

At Frequency (CPS)	500	1000	2000
Convert ASA to ISO by adding	15	10	10

(4) Uniformity in analyzing data obtained in audiometric examination for adjudication and review is essential. Reference standards must be clearly indicated as ANSI, ISO, or ASA. No individual shall be considered for rating unless member has been evaluated by an audiologist.

b. 6200, Otitis Media, Suppurative, Chronic. The 10 percent rating during the continuance of the suppurative process is intended as compensation for the existence of active pathology rather than for additional impairment of the individual sense organ. This rating is therefore limited to 10 percent whether the pathological process is unilateral or bilateral.

c. 6207, Deformity of Auricle. If associated with disfiguring scars of face or head, diagnostic code 7800 may be appropriate. The rule against pyramiding shall be applied.

18. 6300-6354, Systemic Conditions.

a. 6309, Rheumatic Fever. Residual impairments will be rated under the appropriate diagnostic code. When a member is determined to be unfit due to recurrence of disease, and there is no residual functional impairment, consider using the zero percent rating.

b. 6350, Lupus Erythematosus, Systemic. Collagen diseases will be rated under this diagnostic code. Sarcoidosis is a variable disease that in analogous to Lupus and this analogy allows residuals or the active disease to be rated, whichever is higher.

c. 6351, Acquired Immunodeficiency Syndrome (AIDS). Policy under determination.

d. 6354, Chronic Fatigue Syndrome. Rate Fibromyalgia, Myofascial Pain Syndrome, and Myofasciitis analagous to this diagnostic code.

9.B.19. 6519, Aphonia, Organic. Impairment of ability to speak may be ratable under more than one diagnostic code, depending upon the cause and severity of the impairment. In such instances, the highest applicable rating will be awarded. This instruction does not apply to speech impairment due to loss of whole or part of the tongue, which is to be rated under diagnostic code 7202.

20. 6600-6603, Diseases of the Trachea and Bronchi, and Pulmonary Emphysema. Appropriate ventilatory function studies must be included in clinical records to support the diagnosis and degree of severity in these pulmonary diseases.

21. 6721-6724 and 6731, Inactive Tuberculosis. After tuberculosis (pulmonary or non-pulmonary) has been inactive for at least 6 months as defined below, the history thereof does not present a manifest or latent impairment of function and is therefore not considered to be a physical disability.

22. Residuals of Inactive Non-pulmonary Tuberculosis. Graduated ratings for inactive non-pulmonary tuberculosis shall not be applied. After the condition has become inactive, residuals (e.g., ankylosis, surgical removal of a part, etc.) are rated under appropriate diagnostic code for the specific residual preceded by the diagnostic code for the tuberculosis of the body part affected, e.g., tuberculosis of the hip joint with residual ankylosis, coded as 5001-5250.

23. 6721-6724 and 6731, Inactive Pulmonary Tuberculosis.

a. Determining Inactivity. Pulmonary tuberculosis is considered to be inactive:

(1) When these criteria are met: No symptoms of tuberculosis origin. Serial roentgenograms must be stable or show very slow shrinkage of the tuberculous lesion. No evidence of cavity. Sputum or gastric washings negative on culture or guinea pig inoculation. These conditions shall have existed no less than 6 months.

(2) On a date of inactivity established by evaluation. This is usually, but not always, at the time the patient is declared to have received the maximum benefits of hospitalization.

(3) Six months after surgical excision of an active lesion during which time there shall have been no evidence of tuberculous activity in any body system, or upon discharge from the medical treatment facility, whichever is later.

9.B.23. b. Chemotherapy. Treatment by medication is frequently continued beyond the date when the disease becomes inactive according to the above criteria. The ending date of such treatment schedule should not be confused with that of the beginning of the inactive status.

c. Rating Residuals. A rating of 100 percent for one year after the date of attaining inactivity will not be used. After the condition becomes inactive, residuals, e.g., impairment of pulmonary function, surgical removal or resection of a part, etc., will be rated under the appropriate diagnostic code, subject to the limitations contained in 4.96(a) of the VASRD except for the reference to Public Law 90-493.

24. 6800-6802, 6811, 6812 and 6818, Non-Tuberculous Diseases. Appropriate pulmonary function studies must be included in clinical records to support the diagnosis and degree of severity of any of these pulmonary diseases.

25. 6814, Pneumothorax. Do not apply "100 percent for 6 months" rating. Rate the underlying condition, if known, or consider rating by analogy to emphysema (diagnostic code 6603) or pneumoconiosis (diagnostic code 6802).

26. 6815, Pneumonectomy. The 60 percent rating is applied for pneumonectomy, regardless of the number of ribs removed at the time of the operation. If at a later date thoracoplasty becomes necessary for obliteration of space within the thorax, the rating for pneumonectomy will be combined with a rating for removal of ribs. Note (2) which follows diagnostic code 5297 in VASRD provides guidance in a case of this type.

27. 6816, Lobectomy. An entire lobe other than the right middle lobe must be removed for the defect to be ratable. Excision of the right middle lobe, segmental resection or lingualectomies are not ratable.

28. 6899, Sarcoidosis. This disease is difficult to rate because of its unpredictable course and the number of body systems that may be involved. It is usually rated by analogy to coccidiomycosis (diagnostic code 6821) or pneumoconiosis (diagnostic code 6802) when the predominant manifestation is in the lungs. With other organ or more generalized involvement and manifestations such as lymphadenopathy, transient joint pains and occasional febril episodes, assignment of the diagnostic code 6399 and rating under diagnostic code 6316 may be appropriate.

9.B.29. 7000 Series, Cardiovascular Disease.

a. General. To avoid pyramiding, only one rating should be given for all manifestations of cardiovascular-renal disease when, according to accepted medical principles, the conditions are etiologically related. For example, hypertension, arteriosclerosis and nephritis involving vascular abnormalities are so closely associated that they may be regarded as one clinical entity. The disability should be rated under the diagnostic code representing the predominant signs and symptoms. Occasionally the related manifestations in another body system will be so severe as to increase the member's overall impairment to the point that the next higher percentage under the selected diagnostic code will be justified. The note in the VASRD under diagnostic code 7505 is pertinent in this respect.

b. Valvular Heart Disease. Valvular heart disease not of arteriosclerotic or hypertensive origin should be rated as rheumatic heart disease, diagnostic code 7000.

c. 7000, Rheumatic Heart Disease.

(1) Assumption of the existence prior to service of a ratable degree of rheumatic heart disease is sometimes justified even though its presence was not previously recorded. Such an assumption, of course, would depend upon its compatibility with the interpretation of medical history and findings in the light of accepted medical principles. A stenotic valvular lesion discovered early in military service is an example of such a condition.

(2) A "definitely" enlarged heart is one in which there is positive evidence of enlargement beyond the doubtful or borderline enlargement that is sometimes reported when the presence of enlargement is uncertain. Voltage criteria (abnormalities) alone are not acceptable as electrocardiographic evidence of definite enlargement.

(3) The 100 percent rating for active rheumatic heart disease for six months is not applicable.

(4) Following valvulotomy or other corrective cardiovascular procedure, rate as discussed in 7005-7006 (5) below.

9.B.29. d. 7005-7006, Arteriosclerotic Heart Disease, Myocardial Infarction.

(1) A rating for arteriosclerotic heart disease is not to be combined with one for hypertensive heart or hypertensive vascular disease (diagnostic codes 7007 or 7101).

(2) A rating of 100 percent under this diagnostic code solely on the basis of the acute attack occurring within a six month period will not be applied.

(3) In assigning percentages under these diagnostic codes the criteria are as follows:

(a) The 100 percent rating: following a myocardial infarction in which complications are so severe (e.g., intractable angina or intractable congestive heart failure) as to generally confine the individual at home or comparable environment, or following a myocardial infarction complicated by persistent or frequent episodes of congestive heart failure or other significant complication requiring continued active therapy, such as use of digitalis, diuretics and/or similar supportive measures. More than strictly sedentary employment precluded.

(b) The 60 percent rating: following a myocardial infarction with substantiated repeated attacks of angina pectoris at rest or with normal activity, or substantiated repeated attacks of angina pectoris without antecedent myocardial infarction. More than light manual labor is precluded. The term "substantiated" as used here means the existence of a clinical and/or medical history, or other documentation, which tends to support the diagnosis.

(c) The 30 percent rating: following a myocardial infarction manifested by a definite clinical history and expected laboratory evidence and/or characteristic electrocardiographic changes, or electro-cardiographic evidence which is diagnostic of a previous myocardial infarction without continuing symptoms indicative of compli-cations of arteriosclerotic heart disease. Also, angina pectoris where ordinary activity does not cause frequent pain, but where strenuous activity is precluded.

9.B.29. d. (4) When an infarction or other acute conditions evaluated under these diagnostic codes has occurred within approximately 6 months preceding evaluation, or when the member's condition does not appear to have stabilized sufficiently to permit evaluation, place on the TDRL and remove as soon as clinically stabilized.

(5) Injuries, surgical procedures, pacemakers:

(a) Wounds, retained fragments or surgical procedures that disrupt the integrity of the myocardium or the conduction system, are rated for residual impairments raised to the next higher level.

(b) Ratings for heart injuries may be assigned in conjunction with disabilities rated as residuals of pleural injuries under diagnostic code 6818. Since these ratings are for separate injuries, ratings under both diagnostic codes will not be considered pyramiding.

(c) Coronary bypass procedures, valve reconstruction or prosthesis, pacemakers and other significant procedures must be individually evaluated as the case merits. Members found unfit for continued duty will be placed on the TDRL with a minimum rating of 60 percent, if within six months of surgery. Upon removal from the TDRL, if still considered unfit because of physical disability, rate for residuals based upon underlying pathology raised to the next higher level with the exception of coronary bypass procedures, which ordinarily will be rated on residuals alone. The 30 percent rating based solely on the performance of surgery will not apply to evaluee's previously found fit for duty, unless the evaluee is subsequently found unfit for continued duty by reason of some other impairment.

(6) Definition of Terms as used in VASRD.

(a) "Ordinary manual labor" includes work not involving sustained heavy energy expenditure and includes most skilled laborers, mechanics, and drivers.

(b) "Strictly sedentary employment" involves low energy expenditures and minimal body movement.

9.B.29. e. 7007-7101, Hypertensive Heart Disease and Hypertensive Vascular Disease. Blood pressure readings to be used in determining disability rating percentages should be obtained under normal circumstances and during usual activities. When antihypertensive medication is required for control, the rating is based on the pressures obtained during usual activities while under medication. It should be emphasized that hypertension brought under control through optimum conditions, that is, during hospitalization under a regimen of medication and enforced rest, will not be used as a basis for evaluation unless it is established that such control continues upon resumption of normal activity. Similarly, readings obtained during periods when indicated medication is withheld for purposes of medical observation, diagnostic study, etc., are not to be used as the basis for evaluation. A minimum of 10 readings taken on at least 5 days, on treatment, and under conditions as close as possible to normal duty performance, will be necessary. Blood pressure levels should also be correlated with other evidence of end organ change, such as eyeground, neurologic, etc. It should be appreciated that the member, while in a hospital status, may be engaged in activities which, for adjudicative purposes, are considered as unrestricted and comparable to "outside of the hospital environment." For example, the member is ambulatory to the mess hall, receives weekend passes, engages in ward housekeeping duties. The level of hypertension is not to be determined by an average of all readings, but rather, the predominant readings will be the basis for determining the level of hypertension.

f. 7007, Hypertensive Heart Disease.

(1) Diagnostic code 7007 is not to be combined with diagnostic codes 7005 or 7101. When a combination of 7007 or 7101 exists with 7005, rate the individual under the diagnostic code that most accurately reflects the disability. The presence of stigmata of hypertensive disease does not warrant rating at a higher level, unless there is clinically significant secondary organ involvement, such as renal impairment. When significant changes are present, consider raising the rating one step.

(2) Careful evaluation is necessary in making the frequently tenuous distinction between hyper-tensive heart disease and hypertensive vascular disease, especially for the minor degrees of severity. Generally, to justify the 30 percent rating for hypertensive heart disease, all of the

9.B.29.f. (2) (cont'd) criteria mentioned in the VASRD for that rating shall be met. "Definite enlargement of the heart" means certain left ventricular hypertrophy by ECG criteria, other than voltage alone, with allowance for T-wave changes which may reflect medication more than pressure. The x-ray appearance of the heart is deceptive in concentric hypertrophy, but must be at least consistent with that diagnosis. Echo cardiography evidence should usually be included as proof of enlargement.

g. 7015, 7016, 7017, 7110, Surgical Procedures Associated with AV Block, Heart Valve Replacement, Aneurysms.
Convalescent ratings and ratings for specified periods of time following surgery will not be applied. Rate on the basis of functional impairment. However, maximum ratings do apply. Although relatively few symptoms may exist following the insertion of a graft in treatment of this condition, the residual of such graft insertion usually warrants a 20 percent rating under diagnostic code 7110.

h. 7099/7005, Aortic Grafts. The possible grave prognosis for a member who has an aortic graft should be kept in mind when evaluating this condition. Although relatively few symptoms may exist following the graft, this procedure usually warrants a 30 percent rating under diagnostic codes 7099/7005 on the basis of latent impairment. If symptomatology still exists following the grafting procedure, it should be rated according to the VASRD for the underlying condition.

30. 7100, Arteriosclerosis, General. The 20 percent rating under this diagnostic code is rarely appropriate. Manifestations of the disease should be rated for impairment of the body system involved to the greatest condition.

31. 7114-7117, Peripheral Vascular Disease.

a. The symptoms and signs of each of these conditions are to be considered as manifestations of a systemic disease entity wherein bilateral involvement of extremities is natural and expected. They are distinct from local mechanisms affecting peripheral circulation, for example, varicose veins or phlebitis, in which bilateral involvement is more nearly equivalent to coincidental duplication of the disease rather than its direct extension.

9.B.31. b. When manifestations are limited to the extremities, the percentage of disability is to be based upon the most severely affected extremity. The rating of that extremity is to be used as the total percentage, unless each of the two or more extremities separately meets the requirements for evaluation in excess of 20 percent. In the latter case, 10 percent only will be added to (not combined with) the evaluation for the more severely affected extremity, except where the disease has resulted in amputation. When both upper and lower extremities are involved, the above procedure will be applied to the upper extremities, then to the lower extremities. These ratings will be combined if each group has a total rating in excess of 20 percent.

c. The bilateral factor should be applied in all cases of an amputation of one extremity with any compensble degree of disability of the other extremity.

d. A peripheral vascular disease rating of 20 percent or less will not be combined with any other peripheral vascular disease rating.

e. Use the chart below in rating peripheral vascular disease for diagnostic codes 7114 through 7117.

PERIPHERAL VASCULAR DISEASE RATING CHART

One Extremity Involved	Combined Rating
20	20
40	40
60	60
Two Extremities, Not Paired (one arm and one leg)	
20 and 20	20
40 and 20	40
40 and 40	60
60 and 20	60
60 and 40	80
60 and 60	80
Two Paired Extremities (two arms or two legs)	
20 and 20	20
40 and 20	40
40 and 40 (40 + 10)	50
60 and 20	60
60 and 40 (60 + 10)	70
60 and 60 (60 + 10)	70

CONTINUED ON NEXT PAGE

Exhibit 9-4

PERIPHERAL VASCULAR DISEASE RATING CHART
CONTINUED FROM PREVIOUS PAGE

Three Extremities Involved

Paired Extremities	Other	
20 and 20	20	20
20 and 20	40	40
20 and 20	60	60
40 and 20	20	40
40 and 20	40	60
40 and 20	60	80
40 and 40	20	50
40 and 40	40	70
40 and 40	60	80
60 and 40	20	70
60 and 40	40	80
60 and 40	60	90
60 and 60	20	70
60 and 60	40	80
60 and 60	60	90

All Extremities Involved

Paired Extremities	Paired Extremities	Combined Rating
20 and 20	20 and 20	20
40 and 20	20 and 20	40
60 and 20	20 and 20	60
40 and 40	20 and 20	50
40 and 20	40 and 20	60
40 and 40	40 and 20	70
40 and 40	40 and 40	80
60 and 40	40 and 40	90
60 and 40	60 and 40	90
60 and 60	40 and 40	90
60 and 60	60 and 40	90
60 and 60	60 and 60	90

Exhibit 9-4 (cont'd)

32. 7307, Gastritis, Hypertrophic. Identification by gastroscopic examination is required to establish diagnosis.

33. 7308, Postgastrectomy Syndrome In evaluating and rating, take care to differentiate between nondisabling symptoms or minor discomfort which sometimes result from overindulgence, such as that experienced from overeating by a person without a gastrectomy, and discomfort symptomatic of a true postgastrectomy syndrome. Circulatory symptoms, even though mild or intermittent, or comparable symptoms such as a need for rest regularly after meals are indicative of disability which may be a basis for rating.

9.B.34. 7328-7329, Intestinal Resections. Where portions of both intestines have been removed, rating should be made under the diagnostic code which is most representative of the clinical manifestations.

35. 7332-7336, Ano-Rectal Conditions. Pilonidal cyst or sinus is primarily a disorder of ectoderm and should be rated as a skin condition except when an active process is present when it should be rated by analogy to diagnostic code 5000.

36. 7338, Hernia, Inguinal. If correctable, hernia is not ratable even though operation is refused, unless complicated by circumstances contraindicating surgery, such as poor muscular or fascial structure, senility, psychosis, or serious disease which would interfere with healing or be aggravated by surgery, and the presence of other disabilities so serious or advanced that herniography would serve no useful purpose.

37. 7345, Hepatitis, Infectious.

a. Acute infectious hepatitis may be associated with "A", "B", or variant antigens and will usually resolve without residual impairment at the time liver function tests return to normal.

b. Chronic persistent hepatitis is a condition exhibiting minimally disturbed histology and liver function tests. It causes no, or minimal, persistent disability or progression and rating for residuals is seldom justified. However, placement on the TDRL may be appropriate when the clinical and laboratory course, particularly in the presence of persistent antigenemia, indicate a need for continued observation to rule out chronic active hepatitis. This problem is not always resolved by liver biopsy and both time and supporting evidence may be needed.

c. Chronic active hepatitis is a serious frequently progressive condition that may or may not be readily associated with a demonstrable antigen. Since the outcome is difficult to predict, placement on the TDRL may be appropriate prior to permanent disposition.

d. Rate other forms of inflammatory or infectious liver disease by analogy to infectious hepatitis or to other specific diagnostic codes, if applicable.

38. 7347, Pancreatitis. Rate diabetes mellitus, if present, separately.

39. 7500-7531, The Genitourinary System. Sterility and impotence are not ratable entities.

9.B.40. 7703, Leukemia. If the use of chemotherapeutic agents is required, rate as leukemia requiring irradiation or transfusion.

41. 7709, Lymphogranulomatosis (Hodgkin's Disease).

a. Cases in remission with minimal residuals may not be unfitting. Staging is the basis for clinical management of Hodgkin's Disease under treatment. Rating and disposition may be carried out according to the following guide.

HODGKINS DISEASE RATING AND DISPOSITION GUIDE

Stage	(Stage A) Rating	(Stage B) Rating	Disposition (if unfit)
I	30	60	TDRL
II	30	60	TDRL
III	60	--	TDRL
III	--	100	TDRL
IV	100	100	TDRL

Exhibit 9-5

b. Upon removal from the TDRL, if found unfit, the condition will be rated for residuals only. Splenectomy, if performed in the course of diagnosis, staging or treatment, will not be rated separately, since it is generally performed incident to the direct management of the condition, and a separate rating constitutes pyramiding. However, if the residuals are rated less than 30 percent, then the policy of the higher of the two evaluations applies, and the 30 percent splenectomy rating would be assigned.

42. 7714, Hemoglobinopathies. The VASRD rates all the manifestations of sickle cell disease and its variants. Individuals with the more severe hemoglobinopathies are not acceptable for entry into the military services and appropriate policies concerning line of duty and service aggravation apply.

43. 7801, Scars, Burns, Third Degree. The following instruction will supplement the criteria under diagnostic code 7801 in the VASRD to permit a realistic rating of actual impairment of function:

a. Third degree burn scars which cause limitation of function of underlying structures should be rated by analogy to other diagnostic codes which reflect the functional impairment.

9.B.43 b. Rate unsuccessfully healed or grafted areas according to diagnostic code 7801. Footnotes in the VASRD apply.

c. Rate successfully grafted third degree burn areas as second degree burns under diagnostic code 7802. The footnote in the VASRD applies.

d. The following may help in calculating burn area:

Avg. 70 kg. (150 lb) male body surface = 1.7 sq. meters
2636 sq. in. = 18.3 sq. ft.
1 meter = 39.37 inches
1 sq. meter = 1550.6 sq. in.

44. 7802, Scars, Burns, Second Degree. Diagnostic code 7802 limits rating to 10 percent for second degree burns affecting an area or areas approximately 1 square foot. When there are widely separated areas and each is approximately 1 square foot or more, 10 percent may be assigned for each scar.

45. 7804, Scars, Superficial, Tender and Painful. This rating of 10 percent may be assigned whenever the requirements are met for the area of involvement even though the rating may exceed the amputation rating, but only if the amputation rating is 0 percent. Do not combine a rating assigned for a scar under these circum-stances, with any other rating for disability which involves the same area or digit. Figure 9-2 provides the

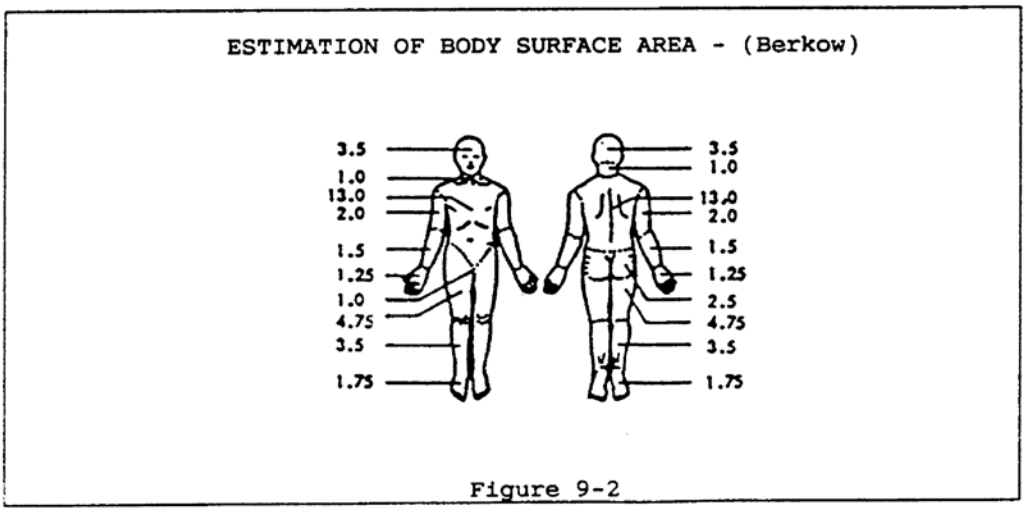


Figure 9-2

basic scheme for estimating percentage of body surface area. Exhibit 9-6 is a table provided for convenient conversion from percentage of body surface area to actual surface area measurement in square inches and square feet. It is based

9.B.45. (cont'd) upon application to the "average 70 kg. man" (approximately 154 lbs.) with a body surface area of 2,636 sq. in. (18.3 sq. ft.).

BODY SURFACE AREA

Body Surface	% Body Surface	AREA Square Inches	AREA Square Feet
Anterior or posterior head	3.5	92	0.64
Anterior or posterior neck	1.0	26	0.18
Anterior or posterior trunk	13.0	343	2.38
Anterior or posterior arm	2.0	53	0.37
Anterior or posterior forearm	1.5	40	0.27
Dorsal or palmar hand and fingers	1.25	33	0.23
Buttock	2.5	66	0.46
Genitalia	1.0	26	0.18
Anterior or posterior thigh	4.75	125	0.87
Anterior or posterior calf	3.5	92	0.64
Dorsal foot or sole, incl. toes	1.75	46	0.32

Exhibit 9-6

46. 7806, Eczema. Eczema is a disease of the skin, which is a body system in and of itself. As such, the bilateral factor does not apply even if the exzema affects opposite limbs.

47. 7809, Lupus Erythematosus. This applies to the localized (discoid) type involving only the skin. Systemic lupus erythematosus and collagen diseases should be rated under diagnostic code 6350.

48. 7913, Diabetes Mellitus.

a. The severity of each case is to be individualized, taking into consideration complications, age of the member, and ease or difficulty in the control of blood sugar levels. However, under normal circum-stances, members whose diabetes mellitus requires insulin for control will be found unfit for continued duty and not retained.

b. Rating should be determined primarily on complications, need for frequent hospitilization, ease or difficulty of control of blood sugar, and not on insulin dosage.

c. According to accepted medical principles, a "large" daily (24 hour) insulin dosage must be greater than 1.2 units per kilogram body weight.

9.B.48. d. An evaluee whose diabetes is controlled by diet and/or oral medications and who is without impairment of health, vigor, and limitation of activity may be found fit for duty.

49. 8000-8046, Organic Diseases of the Central Nervous System.

a. General. Careful correlation of the note under diagnostic code 8046 in the VASRD with the italicized introduction to diagnostic codes 8000-8046 should enable boards to select the proper rating approach. In some of these conditions, the minimum rating may be awarded on the basis of the diagnosis alone, whether or not there are residuals. If the latter have neither residuals capable of objective verification nor subjective residuals which are credible and consistent with the disease, and are not more likely attributable to other diseases, the condition should be ratable at 0 percent.

b. 8017, 8018, 8023-8025, Progressive Muscular Atrophy and Myasthenia Gravis. Combined rating may be assigned under these diagnostic codes with the bilateral factor added.

50. 8205-8412, Diseases of the cranial Nerves. Notice the provision for combined ratings under these diagnostic codes where there is bilateral involvement, but without addition of a bilateral factor.

51. 8510-8730, Diseases of the Peripheral Nerves. In cases where the rating is made on residuals, observe the general principle of adjudicating on the basis of impairment of function rather than on anatomical diagnosis. For example, a complete paralysis of the circumflex nerve of the major extremity carries a 50 percent rating under diagnostic code 8518. In many cases, however, abduction of the arm where the circumflex nerve is paralyzed, occurs by virtue of other muscles taking over the function of the paralyzed muscles. To warrant the 50 percent rating, the member's residual loss of function must actually include all the defects listed under diagnostic code 8518. When other muscles have, in fact, taken over the function of the circumflex-innervated deltoid, the residual loss of function is properly ratable under diagnostic code 5201, Limitation of Arm Motion, or 5303, muscle injury, Group III, whichever best reflects that predominant impairment. Cases of paralysis of the common peroneal nerve with foot drop, diagnostic code 8521, will be rated in terms of loss of function, rather than topographic-ally. Amputation below the knee, diagnostic code 5165, is ratable at 40 percent. In order to warrant a similar rating for peroneal palsies, there must be sufficiently severe symptoms, such as trophic and circulatory changes and

9.B.51. (cont'd) other concomitants to make the functional impairment reasonably equivalent to actual loss of the foot.

52. 8599, Scalenus Anticus Syndrome. This syndrome should be rated by analogy with the lower radicular group (diagnostic code 8512), or less commonly with either erythromelalgia (diagnostic code 7119) or Raynaud's Disease (diagnostic code 7117), depending upon predominant symptoms and overall functional impairment.

53. 8910-8914, The Epilepsies.

a. Attacks following omission of prescribed medication or the ingestion of alcoholic beverages or other drugs to affect seizure frequency are not indicative of the controlability of the disease; they should not be included in the determination of the disability percentage. If there is evidence of the conditions described above, then it must be presumed that the evaluee would be seizure-free if the prescribed medication therapy were followed and/or ingestion of alcohol or drugs were avoided.

b. Ultimately, members who remain seizure-free while on medication therapy will be rated as having "confirmed diagnosis of epilepsy with a history of seizure," except as determined in accordance with the subparagraph below.

c. On a case-by-case basis, members who remain seizure-free while on medication therapy may be considered fit for duty based on their ability to adhere to the medical regimen, the controllability of the disease, the normalcy of their EEG tracings and their motivation.

d. Seizure activity deriving from organic or pathological causes are generally more appropriately rated under the 8000 or 9300 diagnostic code series in the VASRD.

54. 9201-9210, Psychotic Disorders. Loss of function, reflected in impaired social and industrial adaptability, is the principal criterion for establishing the level of impairment resulting from mental illness. Specifically included are those disorders manifesting disturbances of perception, thinking, emotional control and behavior sufficiently severe to limit capacity to perform military duties or otherwise earn a living. Reference should be made to the member's social and industrial adjustment prior to diagnosed psychiatric illness as a baseline for assessing loss of function. All pertinent data provided by the medical board, TDRL examining physicians, and other competent medical authorities must be carefully reviewed before arriving at a final determination. When

9.B.54. (cont'd) this material is conflicting, the problem issues should be resolved before a rating decision is made, and the action taken to resolve them clearly shown in the record of proceedings. It is often difficult to properly assess the degree of permanent impairment resulting from a psychotic process during the weeks immediately following an acute episode. On occasion, a member's period of intensive in-hospital treatment has not been completed at the time of the initial medical board action. With the passage of time, the clinical picture tends to stabilize, and the degree of permanent impairment may then be more accurately estimated. For purposes of assessing impairment resulting from most types of schizophrenia and the major affective psychoses, placement on the TDRL is warranted. Ratings should be based on actual industrial inadaptability. Social inadaptability and symptomatology (such as autism, affect-disturbance and loosening of associations) are to be evaluated only as they affect industrial adaptability. See 4.125 through 4.131 of the VASRD.

a. Complete. Members receiving this rating on either a temporary or permanent basis will most often be declared incompetent and, if not transferred to a Department of Veterans Affairs Hospital, be discharged to the care of a relative or guardian. Infrequently a member, though not declared incompetent, may still be entitled to this rating.

b. Severe. The severely impaired category includes members discharged to their own care or the care of relatives when manifesting marked degrees of mental deterioration, emotional impairment, permanent disintegration and poor judgment that does not completely impair social and industrial adaptability. Evaluees determined to have this degree of severity may or may not be found mentally incompetent.

c. Considerable. This category should be reserved for members who require frequent outpatient treatment and medication to maintain employment and avoid rehospitalization and who despite treatment, exhibit extensive job instability and experience periodic relapses requiring hospitalization.

d. Definite. The member requires occasional outpatient treatment and medication to maintain employment and avoid rehospitalization, and may do well on this treatment program, though he or she may experience some job instability. Often the illness may interfere with his or her advancement.

9.B.54 e. Considerable and Definite. These degrees of severity are considered appropriate when the member has potential employability. A member's overall life adjustment and degree of potential employability will be considered in a choice of the degree of severity. Members determined to have these degrees of severity will generally not be found mentally incompetent and outpatient therapy and/or anti-psychotic medication may or may not be required. Members involved in sheltered employment such as working for family members will most often fit in one of these categories.

f. Mild. The "mild" degree of severity will be appropriately applicable subsequent to psychotic episodes, with or without residuals, when none of the foregoing is applicable. Outpatient therapy may or may not be required, but generally, anti-psychotic medication is not required.

g. Full Remission. This category will be used when a psychosis is in full remission and has had little permanent effect on the member's personality. The member will not be in need of medication, follow-up, or medical supervision. Rate as "zero percent".